# VAN NATTA'S
# WORKERS' COMPENSATION REPORTER

VOLUME 45

(Pages 1-714)

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 precedental value.

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Edited & Published by:

Robert Coe and Merrily McCabe
1017 Parkway Drive NW
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(503) 362-7336

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## CITE AS

45 Van Natta ____ (1993)

In the Matter of the Compensation of
**KEVIN G. ELLER, Claimant**
WCB Case No. 90-19830
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The self-insured employer requests review of Referee Baker's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) awarded claimant an assessed attorney fee of $3,000 for prevailing against the denial. On review, the issues are compensability and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following modification. Instead of the Referee's last finding, we find that claimant's tire work was not the major contributing cause of a worsening of claimant's bilateral carpal tunnel syndrome.

## CONCLUSIONS OF LAW AND OPINION

Claimant's carpal tunnel syndrome (CTS) condition, because it is alleged to have resulted from a series of traumatic events or occurrences at work, must be analyzed as an alleged occupational disease under ORS 656.802(1)(c). In order to establish the compensability of that condition, claimant must prove that work activities were the major contributing cause of the CTS or its worsening. See ORS 656.802(2).

Here, we find that claimant had preexisting CTS, based on the undisputed fact that claimant experienced carpal tunnel symptoms while working for an earlier employer at a plywood mill in late 1987.[1] Therefore, claimant must prove that tire work activities were the major contributing cause of a worsening of the preexisting CTS. A worsening of symptoms is not sufficient; claimant must also prove a worsening of the underlying disease. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Because this issue presents a complex medical question, the resolution of the issue turns largely on the 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 medical evidence is divided. Dr. Grant, the attending physician, opined that the repetitive hand activities required to perform the tire work were the major contributing cause of a worsening of the underlying CTS. (Ex. 14A). He explained that the CTS symptoms coincided temporally with the tire work and that the fluctuation of symptoms "must have a neurophysiological basis and therefore there must in fact be an objective change in the 'underlying disease process.'" (Id.). Dr. Webb, who examined claimant at Dr. Grant's request, opined that the CTS symptoms were caused by the tire work. (Ex. 6).

Dr. Nathan, on the other hand, performed an independent medical examination and opined that the tire work was not the major contributing cause of any worsening of the preexisting CTS. (Exs. 8, 14). Based on claimant's history of prior CTS symptoms while working at the plywood mill, Dr. Nathan opined that claimant had chronic entrapment neuropathies involving both median nerves which predated the tire work. Although he acknowledged that claimant's symptoms had resolved before commencing the tire work, he found no objective evidence that the underlying neuropathies had

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[1] By letter dated November 1, 1990, the self-insured employer notified claimant that, in addition to denying the compensability of his CTS claim, it was also disclaiming responsibility on the basis that claimant's earlier employment with Gold Beach plywood mill was the major contributing cause of the CTS. The letter notified claimant that he had 60 days in which to file a claim against Gold Beach. Given this notice, the employer was permitted to assert, as a defense, that actual responsibility for the CTS claim lies with Gold Beach, regardless of whether claimant actually filed a claim against that employer. See ORS 656.308(2); cf. Richard F. Howarth, 44 Van Natta 1531 (1992). We find no indication in the record that claimant filed a claim against Gold Beach. Accordingly, we analyze claimant's prior symptoms while working for Gold Beach as a preexisting condition.

resolved. He explained that the fluctuation of symptoms does not prove a change in the underlying disease process. (Ex. 14).

Dr. Nathan also noted that claimant's tire work activities did not correspond with the location of the lesions of the median nerves. Specifically, he noted that, whereas claimant reported using pneumatic tools at work primarily in the right hand, nerve conduction studies showed median nerve abnormalities were symmetric bilaterally. He also suggested that claimant's weightlifting activities and previous employment in the plywood mill were the major cause of the CTS. (Ex. 14).

In response to Dr. Nathan's reports, Dr. Grant noted that claimant's carpal tunnel problems at the plywood mill had resolved after he stopped working there and that claimant never experienced any CTS problems during weightlifting activities. He also noted that claimant's carpal tunnel symptoms are worse on the right and that, although the tire work involved primarily right hand work, claimant used both hands to perform the work. (Ex. 14A).

After reviewing the medical opinions, we find Dr. Nathan's opinion to be most persuasive because it is thorough and better reasoned. See Somers v. SAIF, 77 Or App 259, 262 (1986). He persuasively explained that claimant has chronic entrapment neuropathies and that fluctuating symptoms do not establish a change of those underlying neuropathies. That explanation is supported by Dr. Grant's March 25, 1991 report, which noted that claimant's CTS symptoms are "much better" since quitting the tire work, notwithstanding the fact that electrodiagnostic studies still revealed "moderately severe" abnormalities of both median nerves. (See Ex. 16-2). Dr. Nathan also persuasively explained that the tire work activities, which primarily required use of the right hand, did not correspond with the location of lesions of the median nerves.

Dr. Grant, on the other hand, appeared to rely on the fluctuation of CTS symptoms to establish a worsening of the underlying condition. However, he does not explain the rationale for that opinion. In view of Dr. Nathan's well-reasoned opinion that fluctuating symptoms do not necessarily establish a change in the underlying condition, we do not find Dr. Grant's opinion sufficient to establish a worsening of the underlying CTS condition. See Aetna Casualty Co. v. Aschbacher, supra. Dr. Webb's opinion is likewise insufficient to establish a worsening of the underlying condition.

Additionally, Dr. Grant's opinion regarding the causation of claimant's CTS symptoms is based on an incomplete history. Specifically, he was not aware that, during the same period claimant was performing tire work, he was also engaged in regular karate activities three to four nights per week. (See Tr. 32-35). Those activities involved repetitious chops, blocks and punches with the arms and hands. (Id.). Without that history, Dr. Grant's opinion is not persuasive. See Somers v. SAIF, supra; Ronald M. Lyday, 42 Van Natta 2692, 2694 (1990). For these reasons, we conclude that claimant has not sustained his burden of proving his occupational disease claim. Accordingly, the insurer's denial was correct, and the Referee's attorney fee award must be reversed.

## ORDER

The Referee's order dated June 11, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's assessed fee award is reversed.

**Board Member Hooton dissenting.**

The majority concludes that claimant's carpal tunnel syndrome is a preexisting condition requiring claimant to prove that his work with Les Schwab Tires was the major contributing cause of a pathological worsening. It further concludes that claimant has failed to demonstrate a worsened condition, and therefore finds the claim not compensable. The majority errs, both in its factual determinations and in its application of law. Therefore, I must dissent.

The Court has established that claimant need not demonstrate contribution from any particular employment to establish the compensability of a claim for occupational disease. It is sufficient that the disease process is caused by some employment in claimant's employment history. Inkley v. Forest Fiber Products Co., 288 Or 337, 344 (1980). If the claim is caused by some employment in claimant's employment history, claimant is entitled to application of the last injurious exposure rule which assigns

liability to the last employer whose employment could have contributed to causation. The last injurious exposure rule is not applied when claimant demonstrates actual causation. Bracke v. Baza'r, 293 Or 239, 249 (1982).[1]

This claim presents three significant questions. First, is the last injurious exposure rule properly applicable? Second, does claimant's carpal tunnel syndrome preexist all employment in his employment history? And finally, is Les Schwab Tires properly the responsible employer?

LAST INJURIOUS EXPOSURE RULE

Based upon the discussion of claimant's counsel at hearing, it is not possible to conclude that claimant waived the benefits of the last injurious exposure rule, or, even, that he sought to establish affirmatively that his work exposure with Les Schwab Tires was the actual cause of his carpal tunnel syndrome. The only evidence supporting such a conclusion is the reports of Dr. Grant, who indicates that claimant's employment exposure with Les Schwab Tires is the actual cause of his disability and need for treatment. However, these reports were generated prior to the issuance of any denial and prior to claimant's retention of legal counsel to assist in establishing the compensability of his claim. There is no evidence that Dr. Grant discussed the legal ramifications of his conclusions with claimant or that claimant sought Dr. Grant's assistance in establishing actual causation.

Even if claimant sought to demonstrate actual causation, that does not waive application of the last injurious exposure rule. Insofar as claimant failed to establish actual causation, the rule remains applicable. Claimant remains entitled to a determination of compensability based on the application of the last injurious exposure rule.

PREEXISTING CONDITION

The evidence demonstrates that claimant experienced symptoms related to carpal tunnel syndrome while employed in a plywood mill prior to his employment with Les Schwab Tires. That episode resulted in no disability or need for medical treatment. That, however, is not the question anticipated by Weller v. Union Carbide, 288 Or 27, 35 (1979). Because the court has determined that claimant need only show that an occupational disease was caused by some employment in his employment history, it is necessarily true that a condition must preexist any causal employment before it can be considered a preexisting condition under ORS 656.802. Nothing in the present record establishes that claimant's carpal tunnel syndrome preexisted all potentially causal employment. Consequently, a preexisting condition analysis is wholly inappropriate in the present claim.

Indeed, the employer has conceded that claimant's carpal tunnel syndrome is caused by some employment in claimant's employment history. In its denial, it stated that "[i]t is Les Schwab's position that your employment at the plywood mill was a major contributing cause of your bilateral carpal tunnel condition." (Ex. 10).

The majority's conclusion that claimant had a preexisting carpal tunnel syndrome is not supported by any evidence in the record and is contrary to the concession of the employer. It is therefore, erroneous.

COMPENSABILITY

Claimant has not waived the benefits of the last injurious exposure rule as a rule of proof to aid in establishing the compensability of his carpal tunnel syndrome. The employer has conceded that some employment in claimant's employment history is the major contributing cause to the onset of claimant's carpal tunnel condition. Consequently, claimant need only show that the work at Les Schwab Tires is of

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[1] In this claim it appears that the majority has reinterpreted the language of Bracke to conclude that if claimant attempts to demonstrate actual causation, the rule is not applied. However, if the evidence demonstrates that some employment in claimant's employment history caused the disease, and claimant attempts to establish actual causation, the rationale for adopting the rule urged by the court in Inkley does not support punishing claimant for failing to establish actual causation. Bracke indicates only that the rule is not applicable when claimant actually proves causation. In any other circumstances, including claimant's failed attempt to establish actual causation, the rule remains applicable.

the type that could have contributed to the onset or worsening of the disease. Inkley v. Forest Fiber Products Co., supra. The reports of Dr. Nathan, Dr. Jewell and Dr. Grant, when taken together with the historical perspective which indicates an increase in symptomatology concurrent with claimant's employment at Les Schwab and a decrease in symptoms following secession of that employment, indicate that the employment at Les Schwab Tires is of the type that could have caused the condition.

Further, I do not agree with the majority determination that Dr. Nathan is the most reliable of the medical experts. Dr. Nathan addressed only the question whether the employment at Les Schwab Tires actually caused the claimant's carpal tunnel syndrome. The appropriate legal analysis, however, requires expert medical testimony on whether the work at Les Schwab Tires was of the type which could have caused claimant's carpal tunnel syndrome. These questions are very different, and can lead to opposite conclusions, especially where the duration of the last potentially causal employment would argue against actual causation. See, e.g., Inkley v. Forest Fiber Products Co., supra. Moreover, the reports of Dr. Nathan do not establish that claimant's employment with Les Schwab Tires did not contribute to claimant's disability or need for treatment. In fact, Dr. Nathan, by suggesting that treatment is appropriate for a symptomatic aggravation of claimant's nerve entrapment syndrome, demonstrates that the symptoms of carpal tunnel syndrome are the disease for which treatment is provided and from which disability results, rather than the underlying (though in this case not preexisting) entrapment neuropathy. Claimant's employment with Les Schwab Tires did contribute to claimant's need for treatment and disability resulting from carpal tunnel syndrome.

Because the conclusion of the majority is based upon significant errors of both law and fact, I must dissent.

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In the Matter of the Compensation of
**DONALD E. WOODMAN, Claimant**
Own Motion No. 88-0110M
OWN MOTION ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of that part of our December 10, 1992 Own Motion Order which declined to award an assessed attorney fee for services concerning the self-insured employer's request for reduction of his permanent total disability award. Claimant contends that he is entitled to an attorney fee pursuant to ORS 656.382(2). We disagree.

We do not doubt the value of claimant's attorney's services in defending against a reduction of claimant's compensation in the forum of the Board's own motion jurisdiction. Furthermore, we empathize with claimant's attorney's plight in that these services will probably go uncompensated without an award from us of an assessed fee. However, entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984).

ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal. (Emphasis added).

We find that the clear language of ORS 656.382(2) provides for an assessed attorney fee on review to the Board only in regard to services rendered in an appeal of a referee's order. Here, the

employer's request for review was made directly to the Board in its own motion jurisdiction. Thus, the employer's request was not a request for review as that phrase is used in ORS 656.382(2). There is no other statutory authority that would allow an attorney fee in this instance. Accordingly, we are unable to award claimant's counsel an assessed attorney fee.

Claimant argues that the employer's request was essentially an untimely request for review of our earlier April 8, 1988 Own Motion Order and, if the request had been timely filed, claimant would have been entitled to an assessed attorney fee at the Court of Appeals. First, given the decision in Independent Paper Stock v. Wincer, 100 Or App 625, rev den 310 Or 195 (1990), it is not entirely clear that claimant would have prevailed on the merits if the employer had timely appealed the earlier order to the Court of Appeals. Second, the fact remains that the employer did not timely appeal the earlier order and instead unsuccessfully sought review directly to the Board in its own motion capacity. As discussed above, there is no statutory authority for an assessed attorney fee under these circumstances. Consequently, we adhere to our December 10, 1992 Own Motion Order.

Accordingly, we withdraw our December 10, 1992 Own Motion Order. On reconsideration, as supplemented herein, we adhere to our December 10, 1992 order in its entirety. The parties rights to reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ROBB L. RENNE, Claimant**
WCB Case No. 91-17936
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Bottini & Bottini, Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Howell's order that dismissed his request for hearing. On review, the issue is jurisdiction.

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

As a preliminary matter, we substitute "ORS 656.277" in place of the Referee's references to "ORS 656.__."

Claimant requested the hearing to compel the employer to close his 1982 hearing loss claim, which has been classified as nondisabling, or submit the claim to the Department for closure. However, the statutes do not require closure of a nondisabling claim; they require closure of disabling claims only. See ORS 656.268(2), (4). Therefore, like the Referee, we interpret claimant's request as a request for reclassification of his claim as disabling.

Claimant argues that the one-year limitation period for reclassification claims in ORS 656.277 does not apply here because his 1982 injury was misclassified as nondisabling. We disagree.

As amended in 1990, 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."

Subsequent to the Referee's order, the court interpreted this provision in SM Motor Co. v. Mather, 117 Or App 176 (1992). The Mather court stated that if an injury "has been in nondisabling status for one year or more after the date of injury," a claimant has five years after the date of injury

within which to file an aggravation claim. Noting that there was no statutory definition of "nondisabling status," the court applied the definition of a nondisabling injury as set forth in ORS 656.005(7)(d); i.e., an injury that requires medical services only. Applying its analysis, the court reasoned that ORS 656.273(4)(b) applies only to injuries that were nondisabling at the beginning and remain so for at least one year after the original injury. Inasmuch as the claimant's injury was initially disabling (he had three days of compensable temporary disability after the injury), the Mather court held that ORS 656.273(4)(b) was inapplicable and that the claimant had five years from the first closure order under ORS 656.273(4)(a) within which to file an aggravation claim.

Here, claimant's injury was accepted and classified as nondisabling on April 16, 1982. (Ex. 5). Moreover, as the Referee found, claimant's injury was, in fact, nondisabling from the beginning. Finally, the record establishes that the claim remained in this nondisabling status for several years.

Under such circumstances, a claim for aggravation must be filed within five years after the date of injury. See ORS 656.273(4)(b); SM Motor Co. v. Mather, supra. We find no evidence that claimant filed a claim for aggravation within five years from the date of his compensable injury. Accordingly, claimant's aggravation rights have expired, and the Hearings Division lacked jurisdiction to consider his claim.

ORDER

The Referee's order dated March 18, 1992 is affirmed.

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In the Matter of the Compensation of
**OPAL M. SMITH, Claimant**
WCB Case No. C2-03081
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On December 16, 1992, 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 summary sheet provides that claimant fully releases her right to future temporary disability, vocational rehabilitation, survivor's benefits and aggravation benefits. The summary sheet also provides that claimant partially releases her right to permanent disability benefits. On page three of the agreement, however, the parties provide that claimant retains her right to unscheduled permanent disability benefits awarded "with the first closure of the claim, so long as said permanent disability benefits do not exceed 20 percent unscheduled permanent partial disability. In the event that first closure of the claim includes an award of unscheduled permanent partial disability in excess of 20 percent, the employer/insurer specifically reserve the right to appeal and litigate the extent of permanent disability. In the event that unscheduled permanent disability awarded with the first closure of this claim is in an amount of less than 5 percent, claimant reserves the right to appeal the permanent disability award and litigate extent of permanent disability."

We routinely approve claim disposition agreements concerning claims that have not yet been closed. Those agreements, however, uniformly involve a full release of the claimants' rights to permanent disability. Therefore, knowing that the amount of the consideration includes a sum in lieu of permanent disability awarded by claim closure, we are able to evaluate the reasonableness of the consideration. Here, however, the parties are proposing a "partial" release pursuant to which the claim will proceed to closure and, under certain circumstances, litigation of that closure may occur. Given the fact that claimant's ultimate award of permanent disability is contingent on future claim closure and poten-

tial litigation of that closure, we are unable to ascertain whether the amount of consideration is reasonable when compared to the rights being released. Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2); Louis R. Anaya, 42 Van Natta 1843 (1990). Accordingly, we decline to approve the agreement, and we therefore 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 procedure, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SCOTT A. BRADFORD, Claimant**
WCB Case No. 91-16555
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

On November 20, 1992, we issued an Order on Review which awarded claimant's attorney an assessed fee of $3,500 for services on review concerning the successful defense of a Referee's compensability decision. One of our bases for determining this amount was the time devoted to the case, as represented by claimant's respondent's brief and his request for assessed fees. Thereafter, the insurer moved for reconsideration. It asserted that claimant's request for assessed fees represented a request for fees totalling $3,500 for services at both the Hearings Division level and on Board review, rather than an additional assessed fee of $3,500 solely for services on Board review. In the alternative, the insurer argued that a $3,500 assessed fee for services on Board review was excessive.

On December 10, 1992, we withdrew our order for reconsideration. Claimant was granted 10 days within which to respond. Inasmuch as that 10-day period has expired and no such response has been forthcoming, we proceed with our reconsideration.

We agree with the insurer that claimant's request for assessed fees represented a request for a total fee of $3,500 for services at hearing and on review. Claimant's statement of services regarding his attorney's services at hearing listed 22 hours of work performed by his attorney and requested an assessed fee of $2,750. The Referee awarded an assessed fee of $2,750 for claimant's attorney's services on review.

On review, claimant submitted a motion for specific assessed fees with his brief. This motion did not specify whether the work performed related to the hearings level or the Board review level. However, it stated that the approximate time devoted to the case was 32 hours. Given the fact that claimant's attorney spent 22 hours in representing claimant's interests at hearing, we conclude that the 32 hours listed in the motion represents the total time spent on the case. Therefore, we find that claimant requested a total fee of $3,500 for his attorney's services at hearing and on review.

We realize that the time devoted to the case is but one factor in calculating a reasonable attorney fee. See OAR 438-15-010(4). However, given our misunderstanding of claimant's motion for specific assessed fees, we must recalculate the assessed attorney fee for prevailing over the insurer'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 $750, to be paid by the insurer. This fee is in lieu of the $3,500 award granted in our prior order. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and the request for assessed fees), the complexity of the issue, and the value of the interest involved.

Accordingly, our November 20, 1992 order is withdrawn. On reconsideration, as modified and supplemented herein, we adhere to and republish our November 20, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**HOWARD L. CHANT, Claimant**
WCB Case No. 91-03242
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Julie Bolt (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Hoguet's order that upheld the SAIF Corporation's denial of his current heart condition and need for surgery. 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 failed to prove that his current heart condition and need for treatment is compensably related to his 1977 accepted injury. We agree.

In 1977, claimant suffered a myocardial infarction at work. He filed a claim for the myocardial infarction which was accepted as an injury. In 1978, claimant suffered a second myocardial infarction and filed a claim for that attack. On October 25, 1978 SAIF denied the claim on the grounds that the 1978 myocardial infarction resulted from continued progression of coronary atherosclerosis and was not materially related to the accepted 1977 injury. Claimant requested a hearing on the denial and also raised the issue of extent of permanent disability due to the accepted 1977 injury claim.

In a September 10, 1979 Opinion and Order, a referee found that claimant was permanently and totally disabled as a result of his preexisting atherosclerotic heart disease, his chronic obstructive pulmonary disease and his myocardial infarction of August 22, 1977. In that order, the prior referee also stated that the parties had agreed that if claimant was found permanently and totally disabled as a result of his compensable injury, the compensability issue stemming from the denial of the second heart attack in 1978 was moot. The order did not set aside the October 1978 denial and did not decide the compensability issue. Between 1978 and November 1990, claimant had chronic but stable angina.

In November 1990, claimant's angina became unstable and claimant experienced a prolonged episode of chest pain resulting in hospitalization followed by aortocoronary bypass surgery. On January 30, 1991, SAIF denied claimant's current heart condition stating that it was not related to the accepted myocardial infarction.

Claimant first contends that SAIF's January 30, 1991 denial of his coronary artery disease (CAD) is barred by the doctrine of res judicata. Specifically, claimant argues that SAIF had the opportunity to litigate compensability of the coronary artery disease at the hearing in 1978, but chose to forgo that opportunity.

We understand claimant to argue that the agreement of the parties not to litigate the compensability of the second heart attack at hearing somehow rendered the 1978 denial void. We disagree. Although the parties agreed not to litigate compensability of the second heart attack, the 1978 denial was not set aside or in any way affected by the referee's order. As a result, that denial has now become final as a matter of law.

Claimant argues that both issue and claim preclusion apply to bar SAIF from now denying the coronary artery disease. We disagree. The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Issue preclusion acts as a bar only when: (1) the same parties; (2) actually litigate an issue of law or fact; (3) which is necessary to; (4) a valid and final judgment. Carol D. Goss, 43 Van Natta 821 (1991), aff'd mem 110 Or App 151 (1991).

Since the compensability of the CAD was never actually litigated, issue preclusion cannot apply here. Moreover, the issue raised by the 1978 denial and at hearing was compensability of the second heart attack not compensability of the underlying CAD. Therefore, even assuming compensability of the second heart attack was litigated and finally determined by the former referee's order, issue preclusion does not bar either party from now raising the compensability of the CAD.

Under the doctrine of claim preclusion, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, supra at 309; Restatement (Second) of Judgments, Sections 17-19, 24 (1982). A claim is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating, supra. Claim preclusion does not require actual litigation of an issue of fact or law, however, the opportunity to litigate is required, whether or not it is used. Drews v. EBI Companies, 310 Or 134, 140 (1990).

Inasmuch as issue of compensability of the underlying CAD was not raised by the 1978 denial or at the 1979 hearing, there was no opportunity to litigate this issue. Moreover, assuming claim preclusion applies against either party, the medical evidence indicates that claimant's CAD has changed since the 1979 hearing so as to create a new set of operative facts that previously could not have been litigated. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989); Carol D. Goss, supra. Accordingly, the doctrine of claim preclusion does not bar SAIF from now denying that condition.

Claimant next argues that by agreeing that the compensability issue would be moot if he was found permanently and totally disabled, SAIF waived its right to contest compensability of the CAD. We disagree. For a waiver to have occurred, SAIF must have intentionally relinquished a known right. See Drews v. EBI Companies, supra; David M. Marvin, 42 Van Natta 1778 (1990). Waiver will not be presumed or implied contrary to the intention of the party whose rights would be injuriously affected. Waterway Terminals v. P.S. Lord, 242 Or 1, 26-27 (1965). To establish waiver, there must be a clear, unequivocal and decisive act of the party showing such a purpose. Waterway, supra.

Here, we are not persuaded that SAIF intended to relinquish its right to assert that the CAD was not compensable. By agreeing not to litigate the compensability issue, SAIF allowed its denial of the second heart attack to become final. That action does not represent a clear, unequivocal and decisive act demonstrating an intention to give up the right to challenge compensability of the underlying CAD.

Claimant next contends that the doctrine of equitable estoppel should be applied to bar SAIF from denying the heart condition. We disagree.

We have held that equitable estoppel may be applicable against an insurer (or self-insured employer) if all the elements of estoppel are met. The elements of equitable estoppel are: (1) a false representation; (2) made with knowledge of the facts; (3) where the other party is ignorant of the truth; (4) made with the intention that the other party will rely upon it; (5) the other party must be induced to act upon the false representation. Warren H. Charleston, 44 Van Natta 479 (1992); Lamarr H. Barber, 43 Van Natta 292 (1991).

Claimant testified that no one at SAIF told him SAIF would pay for his current heart condition or surgery. Furthermore, we do not find that the parties' agreement not to litigate the compensability issue at the 1979 hearing constituted a representation by SAIF that it would accept the underlying heart condition. On this record, we find no conduct or representation on the part of SAIF that would justify claimant's conclusion that SAIF had accepted responsibility for his underlying heart condition. See also Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992).

Finally, claimant argues that SAIF's denial of the CAD is an improper "back-up" denial of a previously accepted condition under Bauman v. SAIF, 295 Or 788 (1983). We disagree.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Here, SAIF did not specifically or officially accept the coronary artery disease in writing.

Claimant next argues that claimant's accepted 1977 myocardial infarction was merely a symptom of the CAD. Therefore, claimant asserts that under Georgia Pacific v. Piwowar, 305 Or 494 (1988) SAIF accepted the underlying heart condition. We disagree.

In Piwowar, the employer accepted a "sore back." The insurer later discovered that the sore back was caused by a noncompensable condition and attempted to deny that condition. The Court held that the employer had accepted a symptom of the underlying disease rather than a separate condition and the employer could not deny that condition.

Here, SAIF did not accept "heart pain" or a general symptom, but rather accepted a myocardial infarction occurring on a particular date. Whether the specific myocardial infarction can be said to be a mere symptom of the CAD is a medically complex question. Based upon the evidence, we conclude that the accepted myocardial infarction and the coronary artery disease represent two related but separate medical conditions. Although Dr. Ahmad states that the myocardial infarction was "caused" by the CAD, we do not find this opinion, which contains no explanation, sufficient to indicate that a myocardial infarction is a mere "symptom" of CAD. Accordingly, we conclude that the accepted myocardial infarction is a separate condition from the coronary artery disease. Therefore, Piwowar does not apply.

Since we have concluded that SAIF was not barred from denying the CAD, we turn to the merits.

Dr. DeMots, a cardiologist and professor of medicine, did a file review for SAIF. He opined that claimant's coronary artery disease was due to smoking, hypertension and a positive family history. Dr. DeMots further explained that: "It is progression of [claimant's] coronary artery disease that produced the need for surgery. If there had been no progression of the coronary artery disease the surgery would not have been necessary. Bypass surgery is not performed as a treatment for myocardial infarction since the muscle is already dead. It is performed as a treatment for coronary artery disease to increase the supply of blood to the myocardium."

Dr. Toren, cardiologist, also reviewed claimant's records and offered an opinion regarding causation of the CAD. Dr. Toren concluded that the progression of the coronary artery disease was related to smoking, hypertension and possibly elevated cholesterol level. Dr. Toren also opined that surgery was performed not to treat myocardial infarction but to prevent future symptoms of angina and to reduce the risk of mortality. Finally, Dr. Toren concluded that claimant's remote work activities and myocardial infarction did not play a major contributing role in the need for claimant's 1990 bypass surgery.

Dr. Ahmad, claimant's treating cardiologist and surgeon, did not offer an opinion on the causation of the coronary artery disease, but opined that the 1977 and 1990 myocardial infarctions were related to the underlying coronary artery atherosclerosis. Dr. Ahmad also felt that claimant's CAD had progressed since 1977.

Based on the uncontroverted medical evidence, we conclude that the coronary artery disease is not compensably related to the accepted injury. Consequently, we uphold SAIF's denial.

## ORDER

The Referee's order dated January 15, 1992 is affirmed.

In the Matter of the Compensation of
**ROBERT B. CUMMINGS, Claimant**
WCB Case No. 91-15910
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Schultz & Taylor, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Garaventa's order that: (1) upheld the insurer's denial of claimant's injury or occupational disease claim for a thoracolumbar strain; and (2) did not award a penalty and related fee for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

The Referee concluded that claimant had a preexisting mid-back condition for which he had been treated by Dr. Buttler, chiropractor, since at least 1986. The Referee based this conclusion, at least in part, on Dr. Buttler's chart notes (Ex. 12).

On Board review, claimant contends that the Referee erred, because as a layperson she was not competent to "interpret" Dr. Buttler's chart notes. In her appellant's brief, claimant explains:

> "* * * While the records of Dr. Buttler's ongoing treatment regimen of claimant's spine do appear in the record, claimant challenges any Board member, let alone Referee Garaventa, to properly interpret those records. They are certainly Greek to claimant. The physician in the best position to interpret those records, quite obviously, is Dr. Buttler himself. Dr. Buttler explains in Exhibit 39, a January 28, 1992 narrative report to claimant's attorney, the nature of the preexisting spinal problems and how those differ from the condition present on and after August 26, 1991, the initial date of treatment with Dr. Buttler." (Appellant's brief p. 8).

It is not unusual for the lay trier of the facts in a case to interpret medical evidence whether in chart notes or formal reports, particularly in workers' compensation cases, where by statute the "contents of medical, surgical and hospital records presented by claimants [or insurers] shall constitute prima facie evidence as to the matter contained therein." ORS 656.310. The only requirement is that such interpretations have sufficient support in the medical evidence.

In any event, claimant's argument misses the mark. Claimant's attending physician, Dr. Mitchell, M.D., reached the same conclusion as the Referee after reviewing (i.e., interpreting) Dr. Buttler's chart notes. On the basis of that review, Dr. Mitchell reported:

> "[Claimant] may have mentioned that he had been treated by Dr. Buttler before, but until I reviewed the records I did not appreciate the extent of this care. He has been receiving regular treatment from Dr. Buttler for back pain since 1986. On this basis, I would conclude that [claimant] has a pre-existing spinal condition." (Ex. 38).

Thus, it is clear that the Referee did not render her own medical opinion when she made her finding. Rather, the Referee made a finding based on medical evidence in the record which included, but was not limited to, Dr. Buttler's chart notes. That evidence, particularly the opinion of Dr. Mitchell, was clearly sufficient to support the Referee's finding, with which we agree. We also agree with the Referee's conclusion that claimant has failed to establish that his condition was compensably related to work as opposed to being a mere symptomatic exacerbation of his preexisting spinal condition.

Finally, the last full sentence on page three of the Referee's order is corrected to state that claimant's request for penalties and fees for an alleged unreasonable denial is denied.

ORDER

The Referee's order dated April 27, 1992 is affirmed.

In the Matter of the Compensation of
**WILLIAM K. KENNEDY, Claimant**
WCB Case No. 92-08469
And, in the Matter of the Complying Status of
**KIRK STEINERT, Noncomplying Employer**
WCB Case No. 92-06179
ORDER OF DISMISSAL
Bradley A. Peterson, Claimant Attorney
Brothers, et al., Attorneys
Thomas Castle (Saif), Defense Attorney

Claimant has requested review of Referee Hoguet's October 22, 1992 order which: (1) found that claimant was not a subject worker at the time of his injury; and (2) set aside a Director's order finding Kirk Steinert to be a noncomplying employer. The Department of Insurance and Finance (DIF) had filed a cross-request, but has now withdrawn its appeal. We have reviewed this matter to determine whether we have jurisdiction to consider this appeal. We dismiss for lack of appellate jurisdiction.

## FINDINGS OF FACT

On April 21, 1992, DIF published a Proposed and Final Order Notice, declaring Kirk Steinert to be a noncomplying employer. Kirk Steinert requested a hearing.

The parties agreed that compensability of the claim was not at issue at the hearing. Rather, the sole issues pertained to whether claimant was a subject worker and whether Kirk Steinert was a noncomplying employer during three separate periods of time.

Following the hearing, the Referee found that Steinert was a noncomplying employer during two separate periods of time. However, the Referee also found that claimant was not a subject worker at the time of his December 18, 1991 injury. Consequently, the proposed order of noncompliance was set aside. The Referee's October 22, 1992 order included a notice to all parties of their right to appeal to the Court of Appeals within 60 days. On November 16, 1992, the Board received claimant's request for review of the Referee's order.

## CONCLUSIONS OF LAW AND OPINION

We lack appellate jurisdiction to review a referee's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); Ferland v. McMurtry Video Productions, 116 Or App 405 (1992); Spencer House Moving, 44 Van Natta 2522 (1992).

Here, the hearing pertained to Steinert's appeal of the Director's order finding Steinert to be a noncomplying employer and claimant to be a subject worker. Steinert did not contest SAIF's processing of the claim. Moreover, the parties agreed that compensability of the claim was not at issue.

In light of such circumstances, we conclude that the Referee's order concerned only the Director's noncompliance order. Consequently, the Referee's order constitutes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 656.740(1), (3); ORS 183.480(1), (2); Ferland, supra; Spencer House Moving, supra. Accordingly, the requests for Board review are dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
**LYDIA L. KENT, Claimant**
WCB Case No. 91-16337
ORDER ON RECONSIDERATION
Ackerman, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer has requested reconsideration of our December 14, 1992 Order on Review. Specifically, the insurer requests that we authorize it to offset the penalty, awarded pursuant to our order, against overpaid permanent disability benefits. After considering the insurer's motion and memorandum in support, we issue the following order.

ORS 656.268(13) and OAR 436-60-170 allow a carrier to offset overpaid compensation against current and future compensation that is owing to claimant. However, the insurer has provided no authority for the proposition that overpaid permanent disability may be offset against a penalty and we have found none. Moreover, a penalty is not compensation. See Saxton v. SAIF, 80 Or App 631 (1986). Therefore, we decline to grant the insurer's request for an offset in this circumstance.

Accordingly, our December 14, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ARLENE J. KOITZSCH, Claimant**
WCB Case No. 91-04447
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Neal's order that upheld the insurer's denial of her occupational disease claim for a left carpal tunnel condition. On review, the issues are timeliness, waiver and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed an occupational disease claim for left carpal tunnel syndrome (CTS). The insurer denied the claim, asserting that it was not filed timely and that claimant's left CTS had been subject to a September 26, 1989 Disputed Claim Settlement (DCS). The Referee rejected the insurer's timeliness defense, concluding that, although the claim was untimely, the insurer had failed to establish that it was prejudiced by the delay. The Referee agreed, however, that the left CTS was subject to the prior DCS and concluded that claimant was limited to showing that her work activities after September 1989 caused or worsened the condition. Based on claimant's concession that she could not carry that burden, the Referee upheld the insurer's denial.

On review, both claimant and the insurer challenge the Referee's conclusions regarding the timeliness of the claim. Claimant argues that the claim was timely filed, while the insurer contends that it need not establish prejudice because an occupational disease claim is "void" if not timely filed. We conclude that the claim is not time barred. ORS 656.245(4) provides, in part:

"Failure to give notice as required by this section bars a claim under this chapter unless:

"(a) the employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice[.]" (Emphasis supplied.)

In Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), the Supreme Court held that the quoted provision, which relates to accidental injuries, also applies to claims for occupational diseases. See Joanne C. Rockwell, 44 Van Natta 2290 (1992). Thus, even if we assume that claimant failed to give proper notice, her claim is not barred, because the insurer has offered no evidence to establish prejudice.

Claimant also contends that that the Referee erred in concluding that she was precluded from asserting a claim for left CTS as relating to her work activities prior to September 1989. She contends that the prior DCS does not limit her claim, because that agreement only affirmed the insurer's denial of her prior claim for a cervical condition. We agree.

The DCS provides, in pertinent part:

"IT IS HEREBY STIPULATED * * * that Claimant developed right wrist complaints at work on or about September 18, 1988. The employer/carrier denied the condition[.] * * * On April 17, 1989, claimant's treating physician identified a left wrist component to Claimant's complaints, as well as cervical disc disease and noted a potential causal relationship with work. The employer/carrier denied the cervical disease claim[.] * * * There being a bona fide dispute between the parties as to the cervical complaints and the parties wishing to dispose of the cervical condition via disputed claims settlement and all other issues raised or raisable via stipulated order:

"IT IS HEREBY STIPULATED AND AGREED that this matter be comprised * * * by the employer/carrier agreeing (1) to accept Claimant's right carpal tunnel claim: (2) to pay temporary disability * * * (3) to pay the sum of $5,000 to Claimant as and for disputed claim settlement of the cervical disc disease condition; and (4) [pay certain medical expenses]. In consideration of the above payments, agreements and concessions by the employer/carrier, Claimant agrees (1) that there are no complaints, nor is there nor has there been, for left carpal tunnel syndrome against Agripac or Liberty Northwest; (2) to hold harmless the employer/carrier for all and any medical bills or expense incurred and not identified herein which are attributable solely or in part to the cervical disc disease or left wrist complaints and which have not heretofore been paid; (3) that the denial of May 19, 1989 for the cervical disc disease be affirmed and left uncontested; [and] (4) that all issues that were raised or that could have been raised as of the date of the approval of this settlement are hereby resolved." (Ex. 5).

We find no language in that settlement to support a finding that claimant waived her right to assert a claim for left CTS that includes her work activities prior to September 1989. See Dave E. Herman, 42 Van Natta 2104 (1990). Although her treating physician had noted left wrist symptoms, claimant's left CTS had neither been claimed nor denied at the time of the DCS. Claimant's agreement that there was no claim for left CTS simply reflects the fact that, at that time, she had no pain in her left arm, had sought no treatment for the left arm and had not yet had the left arm tested for CTS. Moreover, under those circumstances, claimant's left CTS could not have been the subject of a DCS, because ORS 656.289(4) only allows such disposition of a claim where there is a bona fide dispute over compensability.

We also reject the insurer's contention that claimant could have raised a claim for left CTS at the time of the DCS and, consequently, is now precluded from doing so. The medical evidence establishes that claimant's condition subsequently changed so as to have created a new set of operative facts that previously could not have been litigated. See generally Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989); Argonaut Ins. Co. v. Rush, 98 Or App 730 (1989).

Accordingly, we conclude that claimant's occupational disease claim is neither precluded nor limited by the September 1989 DCS. Because we find the record to be fully developed concerning the compensability of claimant's left CTS condition, we address the merits on review. ORS 656.295(5); Natalia Garibian, 44 Van Natta 244 (1992).

In order to establish the compensability of her left CTS as an occupational disease, claimant must prove by a preponderance of the evidence that her work activities with the insured are the major contributing cause of her condition. ORS 656.802(2). We find the causation of claimant's left CTS is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Claimant relies on the opinion of Dr. Johnson, her treating physician. He opined that claimant's left CTS was directly related to her work activities in the insured's cannery. He relied on the fact that claimant first developed symptoms while performing the work, which involved repetitive and strenuous wrist movements. The insurer relies on the opinion of Dr. Nathan, who did not believe that claimant's left CTS was caused by her work activities with the insured.

When there is a dispute between medical experts, we tend to rely on the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). The insurer contends that such deference is not appropriate here, because Dr. Johnson is not licensed to practice medicine in Oregon and, consequently, not qualified as a "doctor " or "physician" as that term is defined in ORS 656.005(12(a)(b). We disagree for two primary reasons. First, there is no requirement that a physician be licensed to practice in Oregon to qualify as an expert witness. In fact, the Oregon Evidence Code defines an expert witness as one "qualified as an expert by knowledge, skill, experience, training or education. OEC 702. Under that definition, Dr. Johnson is qualified to offer an expert opinion as to the causation of claimant's left CTS. See Ronald D. Robinson, 43 Van Natta 1058 (1991). Second, the persuasiveness of a medical opinion is a question of fact and must be decided on a case-by-case basis. See Barrett v. Coast Range Plywood, 294 Or 641 (1983); Thomas v. Liberty Mutual Insurance, 73 Or App 128 (1985).

After our review, we find the opinion of Dr. Johnson to be well-reasoned and based on complete information. Accordingly, we find it more persuasive and give it the most weight. Somers v. SAIF, 77 Or App 259 (1986). We give less weight to the opinion of Dr. Nathan. His opinion appears to be based, in part, on the legally incorrect assumption that claimant was limited to showing that her work activities after September 1989 caused or worsened the condition. (Ex. 14-36). He also testified that whatever caused claimant's right CTS caused her left CTS. (Ex. 14-45). The law of this case is that claimant's right CTS is work related.

Based on Dr. Johnson's opinion, we conclude that claimant has established the compensability of her left CTS as an occupational disease. Accordingly, the insurer's denial is set aside, and the claim is remanded to the insurer for further processing according to law.

Moreover, claimant is entitled to an assessed attorney fee for prevailing against the insurer's 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 reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $7,400, 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 statement of services), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated March 30, 1992 is affirmed in part and reversed in part. The insurer's denial of claimant's occupational disease claim for left CTS is set aside, and the claim is remanded to the insurer for further processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $7,400, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**KENNETH G. MOORE, Claimant**
WCB Case No. 91-15973
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Garaventa's order that: (1) set aside an Order on Reconsideration as invalidly issued; and (2) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Department (WCD). In his brief, claimant argues that his scheduled permanent disability award should be paid at the rate of $305 per degree. On review, the issues are validity of the Order on Reconsideration, jurisdiction and, if the Hearings Division has jurisdiction, rate of scheduled permanent disability.

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

The insurer contends that, because claimant's Request for Reconsideration did not specify claimant's objection to impairment findings, the Director was not required to appoint a medical arbiter prior to reconsideration. We disagree.

In a letter accompanying the Request for Reconsideration, claimant asserted: "The Determination Orders were in error in that they did not include any disability for [claimant's] tinnitus condition." (Ex. 15-2). Whether a party has requested reconsideration based on an objection to impairment findings is a question of fact. Dale A. Pritchett, 44 Van Natta 2134 (1992). In our view, the aforementioned statement in claimant's reconsideration request was sufficient to raise claimant's objection to the impairment findings used in rating his disability. Consequently, we agree with the Referee that the Order on Reconsideration was invalid because no medical arbiter was appointed prior to reconsideration. See Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

Claimant contends that the Referee's order in this matter was "rendered moot" when the Department of Insurance and Finance issued an order abating and withdrawing its Order on Reconsideration before the Referee's order was appealed. In addition, claimant contends that the issues raised at hearing are not ripe for appeal because, inasmuch as the Director withdrew his Order on Reconsideration, the Referee's order did not finally determine claimant's entitlement to compensation. We disagree with both contentions.

As we have stated, the Order on Reconsideration in this matter is invalid. Nevertheless, the Referee had jurisdiction to determine whether the Hearings Division had authority to hear the case. The fact that jurisdiction is found to have remained with the Department and the fact that the Department has apparently recognized that conclusion by exercising its authority to issue an "abatement order" does not render the issue raised in this case (the validity of the reconsideration order) moot. Accordingly, we conclude, as did the Referee, that the Hearings Division lacks jurisdiction over claimant's hearing request from the Order on Reconsideration. See Olga I. Soto, supra.

Finally, due to lack of jurisdiction, we do not reach the proper rate of claimant's scheduled permanent disability award. See Lorna D. Hilderbrand, 43 Van Natta 2721 (1991). However, we note that claimant's contention is not supported by appellate authority. SAIF v. Herron, 114 Or App 64 (1992), rev den 315 Or 271 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 validity of the Order on Reconsideration is $250, 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 January 31, 1992, as reconsidered March 20, 1992, is affirmed. For services on review, claimant's attorney is awarded an attorney fee of $250, payable by the insurer.

In the Matter of the Compensation of
**SUZANNE M. REID, Claimant**
WCB Case No. 91-15131
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The insurer requests review of those portions of Referee Bethlahmy's order which: (1) set aside its denial of claimant's aggravation claim for a thoracic strain condition; and (2) awarded a $2,000 attorney fee under ORS 656.386(1). On review, the issues are aggravation 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 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 her symptoms have increased or that her condition has worsened so that she 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); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991).

Here, on September 8, 1987, claimant was found medically stationary with no permanent impairment by Dr. Johnson. Releasing claimant to regular work, Dr. Johnson noted that claimant had "minimal restrictions to flexion and extension in the mid-thoracic spine." (Exs. 5B; 6). Dr. Johnson placed work limitations upon claimant to not work overhead for more than two hours at a time. Dr. Johnson opined that claimant "will need some palliative care from time to time in the future." (Ex. 5B). No permanent disability benefits were awarded. Thereafter, claimant continued to work with periodic symptoms of pain.

In February 1991, Dr. Proano, family practitioner, assumed management of claimant's chronic thoracic strain condition. At that time, Dr. Proano reported that claimant was experiencing "tenderness and malrotations of the thoracic vertebrae, particularly T3, and tenderness at T5-T6 area." (Ex. 12-1).

On May 13, 1991, Dr. Proano discontinued claimant's physical therapy and noted that she was "having less back pain as long as she keeps up her exercises." (Ex. 12-2). Dr. Proano recommended periodic checkups.

Dr. Proano did not treat claimant for her compensable condition again until July 15, 1991. Finding tenderness throughout claimant's thoracic spine and noting claimant's complaints of daily back pain, Dr. Proano reported that claimant's recent work activity had aggravated her thoracic strain condition. (Ex. 12-4). In response to these findings, Dr. Proano prescribed physical therapy at the frequency of once a week for the following 4 weeks.

On August 30, 1991, Dr. Thomas, orthopedist, and Dr. Duncan, chiropractor, of the Western Medical Consultants, performed an independent medical examination. These consultants previously examined claimant in April 1991. They noted that claimant described her overall condition as "10 to 20 percent better" than when she was seen by the consultants in April 1991. The doctors found that claimant's mid back was still her main concern which she reported was aggravated primarily by prolonged sitting. (Ex. 15-2). They further found that although claimant reported posture-related mid-back and neck pain, there was no objective evidence of injury or impairment, nor any indication that she required additional treatment or arbitrary work restrictions as a result of these pain symptoms. (Id).

Therefore, Drs. Thomas and Duncan reported that since their prior examination, there had been no changes in claimant's objective findings. (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). Here, there are persuasive reasons not to defer to the opinion of Dr. Proano.

We find that the chart notes of Dr. Proano are outweighed by the reports of Drs. Thomas and Duncan. Although Dr. Proano is claimant's current treating physician, his chart notes essentially fail to provide an opinion regarding claimant's current condition. In contrast, Drs. Thomas and Duncan provide a detailed history of claimant's condition, as well as reasoned explanations for their conclusions. Further, Dr. Proano only recently became claimant's treating doctor, whereas Drs. Thomas and Duncan had the opportunity to examine claimant before and after her alleged aggravation of July 1991. Therefore, the opinions of Drs. Thomas and Duncan's opinion are accorded the greater weight. See Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986); Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, after our review and comparison of medical reports, we conclude that claimant has not established by objective findings a worsening of her compensable condition.

Even assuming claimant has established a worsening of her compensable condition by objective findings, to establish a compensable aggravation claim, claimant must also show that the worsening of her compensable condition has resulted in a diminished earning capacity. Specifically, claimant must prove that, because of the worsening she was less able to work in that she was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452, 455 (1991). After conducting our review of the medical and lay evidence, we are not persuaded that claimant's earning capacity has been diminished as a result of her increased symptoms.

Claimant has worked for the same employer for over twelve years. (Tr. 11). During the last four years, she worked as a floater performing various work activities as a "soil sorter." (Ex. 1; Tr. 14, 19). In June 1991, the employer proposed and Dr. Proano approved a new job for claimant in a clerical position. (Ex. 12-3). Dr. Proano noted that this new position would allow claimant to "sit and stand as she is able." (Id). After her complaints of increased pain symptoms in July 1991, claimant continued to perform her regular duties at her clerical job, fulltime and without restrictions.

Claimant contends that restrictions placed upon her by Dr. Proano prevent her access to the full range of occupations available to her prior to her worsening. We disagree.

Dr. Proano, in response to claimant's report of pain after one day of sitting at a computer terminal, noted that claimant should have "an adjustable chair." (Ex. 12-4). Dr. Proano also opined that "other modifications may need to be implemented at the workplace." (Id).

First, we find no evidence that the recommendation for an adjustable chair is a restriction or limitation that prevents claimant access to occupations available to her prior to her worsening. Next, Dr. Proano's indication that "other modifications" may be needed is speculative and, thus, unpersuasive. Moreover, we find that claimant has not sustained any additional restrictions than those already addressed by Dr. Johnson, her treating chiropractor prior to claim closure. (i.e., not to work overhead for more than two hours at a time).

Finally, as discussed above, we find the opinions of Drs. Thomas and Duncan to be more persuasive than that of Dr. Proano. Drs. Thomas and Duncan found that claimant's objective findings had not changed and they recommended no additional treatment or work restrictions. (Ex. 15-3).

Under the circumstances, we find no evidence that claimant was not capable of performing the same work activities than she was at the time of her last arrangement of compensation. Inasmuch as she has not established a diminishment of earning capacity, we conclude that her aggravation claim for her upper back and shoulder conditions is not compensable. In light of our conclusion that claimant has not established a compensable aggravation, we likewise reverse the Referee's attorney fee award.

ORDER

The Referee's order dated March 30, 1992 is reversed in part and affirmed in part. The insurer's aggravation denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**MORRIS W. SALTEKOFF, Claimant**
Own Motion No. 91-0141M
RECONSIDERATION OF OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 18, 1992 Own Motion Order in which we dismissed, as untimely, claimant's request for Own Motion review of the SAIF Corporation's September 4, 1992 Notice of Closure. Claimant contends that he had good cause for not timely filing the request for review.

OAR 438-12-060(1) provides that a request for Board review of an insurer's claim closure "must be filed with the Board within 60 days of the mailing date of the insurer claim closure to be considered, or within 180 days of that mailing date if the claimant establishes to the Board's satisfaction that there was good cause for the failure to file the request within 60 days of that mailing date." The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Here, the mailing date of SAIF's Notice of Closure was September 4, 1992. Claimant's request for review was received by the Board on November 6, 1992, more than 60 days from the mailing date of SAIF's Notice of Closure. However, the request was filed within 180 days from the mailing date of the Notice of Closure. Therefore, if claimant proves good cause for this untimely filing, we can reinstate his request for Board review. We find that claimant fails to meet his burden of proof.

Claimant argues that after receiving the Notice of Closure, he contacted the Own Motion Specialist at the Board sometime in October and informed her that he wanted to request review of that notice. She informed him that he must make the request for Board review in writing. He asserts that he then contacted his attorney who sent a written request for review. This request was received by the Board after the 60 day deadline. Claimant argues that he would have sent the written request himself except that he writes letters only as a last resort because he is embarrassed by his spelling and punctuation.

The September 4, 1992 Notice of Closure informed claimant that he had 60 days from the date of the notice to request Board review in writing. Claimant was aware that the request for Board review must be in writing. His dislike of writing does not constitute "good cause." Furthermore, any lack of good cause by claimant's attorney for the late request for Board review is attributable to claimant. Sekermestrovich v. SAIF, 280 Or 723 (1977). Consequently, we adhere to our prior order which dismissed claimant's request for Board review.

We withdraw our November 18, 1992 Own Motion Order. On reconsideration, as supplemented herein, we adhere to our November 18, 1992 order in its entirety. The parties' rights to reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CANDACE L. SNIDER, Claimant**
WCB Case No. 91-15820
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Daughtry's order that declined to assess an attorney fee for allegedly prevailing over the SAIF Corporation's aggravation denial. On review, the issue is attorney fees.

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

Here, a Determination Order issued on June 17, 1991 which awarded only temporary disability and found claimant medically stationary on April 26, 1991. Claimant's attorney requested reconsideration of that Determination Order. On December 16, 1991, an Order on Reconsideration issued which: (1) found that the claim was prematurely closed; (2) rescinded the June 17, 1991 Determination Order; and (3) declared that the claim remained in open status. (Ex. 23B). Claimant's attorney was awarded an out-of-compensation fee of ten percent of any additional temporary disability created by the order. Id.

In the meantime, by a letter dated July 8, 1991, Dr. Wiggins, attending physician, set forth an aggravation claim. On October 16, 1991, the SAIF Corporation issued a denial of the aggravation claim. (Ex. 21). Claimant's attorney requested a hearing on that denial. In light of the subsequent Order on Reconsideration, the aggravation denial had been rendered moot, a fact conceded by SAIF in its closing arguments at hearing. In other words, SAIF did not seek to defend the validity of its aggravation denial. The issues before the Referee were claimant's contentions that: (1) the aggravation denial was unreasonable; and (2) her attorney was entitled to an attorney fee for prevailing against the aggravation denial.

The Referee found that SAIF's aggravation denial was not unreasonable. Claimant does not appeal that decision. The Referee also denied claimant's request for an assessed fee, reasoning that the aggravation denial was rendered moot as a legal consequence of the Order on Reconsideration. Inasmuch as claimant had not prevailed against that denial as a result of any independent action by her attorney concerning that denial, the Referee concluded that claimant's attorney was not entitled to a carrier-paid fee.

We agree with the Referee's conclusion. We offer the following additional comments.

In Candy M. Kayler, 44 Van Natta 2424 (1992), we recently decided a case involving the same facts. That is, an Order on Reconsideration determined that a claim was prematurely closed thereby rendering moot a subsequent aggravation claim and denial. In Kayler, supra, the carrier did not seek to defend the validity of its denial. Consequently, we found that the claimant did not "prevail" on her aggravation claim. We concluded that the aggravation claim and the insurer's denial of it were rendered moot by operation of law when the Order on Reconsideration set aside the Determination Order as premature. We found that there could be no valid aggravation denial while the claim was in open status, because there could be no valid aggravation claim. Kayler, supra; see also Mindi M. Miller, 44 Van Natta 1671, on recon 44 Van Natta 2144 (1992); Jack J. Ford, Jr., 44 Van Natta 1493 (1992).

We find that the same reasoning applies here. In short, claimant did not "prevail" on her aggravation claim and is, therefore, not entitled to an assessed attorney fee pursuant to ORS 656.386(1).

ORDER

The Referee's order dated March 20, 1992 is affirmed.

In the Matter of the Compensation of
**KATHLEEN J. STEELE, Claimant**
WCB Case No. TP-92014
THIRD PARTY DISTRIBUTION ORDER
Vick & Gutzler, Claimant Attorneys
James E. Shadduck, Defense Attorney

Claimant has petitioned the Board for approval of a third party compromise. ORS 656.587. In the event that we approve the settlement, claimant also seeks the determination of a "just and proper" distribution of proceeds. ORS 656.593(3). We approve the settlement and find that a distribution in which the paying agency receives $4,005.65 is "just and proper."

FINDINGS OF FACT

In November 1989, claimant, a part-time bookkeeper/secretary, sustained a compensable neck and upper back injury as a result of motor vehicle accident when the car she was driving was rear-ended by another vehicle. No property damage was noted. A police report described the accident as "non-injury."

Claimant sought chiropractic treatment for her neck and upper back complaints. Dr. Robinson, chiropractor, diagnosed acute thoracic-cervical and thoraco sprain/strain. Treatment has been conservative, consisting of manipulation, physiotherapy, and exercise. Claimant did not return to her part-time work for the employer, as well as her part-time job with another employer.

In December 1989, claimant filed a workers' compensation claim. Reliance Insurance, on behalf of claimant's employer, accepted the claim as nondisabling. To date, Reliance has incurred $7,015.41 in claim costs, the majority of which is attributable to treatments provided by Dr. Robinson.

In February 1990, claimant's private health carrier (Nationwide Insurance) began providing "personal injury protection" (PIP) payments. Specifically, Nationwide paid $2,620.80 for lost wages.

Reliance also expended $1,060 as payment for a December 1990 independent medical examination (IME) performed by First Northwest Health (FNH). FNH stated that claimant's past medical history revealed two prior motor vehicle accidents: (1) a 1979 "broad-side" accident, which prompted the onset of mid-back pain that subsequently resolved; and (2) a 1980 "rear-end" accident, which resulted in upper back pain that she continues to experience (although it is not a significant problem). FNH also reported a 1984-85 fall from a chair, which caused low back pain that eventually resolved.

Noting "some continued, mild, subjective complaints but * * * no objective abnormalities," FNH diagnosed "cervical strain, by history, resolved." Finding no ratable impairment, FNH concluded that claimant could perform computer work and other work activities without restriction.

Claimant had previously retained legal counsel to pursue a third party lawsuit against the driver of the vehicle that had rear-ended her vehicle. In September 1991, claimant offered $42,083.91 to settle her claim with AllState Insurance Company (the third party's insurer). The offer was composed of $26,000 in general damages, $2,620.80 in PIP reimbursement, $6,451.20 in "outstanding wage loss," and $7,011.91 in "Reliance workers compensation lien."

When no settlement was forthcoming, claimant filed a complaint, seeking damages from the third party for negligence. Claimant requested $4,960 in "economic damages consisting of expenses for medical care and treatment," and $7,776 for "lost wages." Her complaint noted that noneconomic damages would be proven at trial.

A pre-trial settlement conference was held before Circuit Court Judge Lowe in July 1992. At that conference, Allstate offered $10,000 in full settlement. Claimant's counsel forwarded that offer to Nationwide and Reliance. Nationwide insisted on full reimbursement of its $2,620.80 in PIP payments.

After reducing the $10,000 settlement by the PIP reimbursement, attorney fee ($2,459.73), costs ($658.19), and claimant's 1/3 share ($1,420.43), claimant's counsel notified Reliance that its proposed

share of the settlement would be $2,840.85. Reliance responded that it would approve the settlement and accept the proposed share, provided that claimant agreed to release her future workers' compensation benefits pursuant to a claim disposition agreement (CDA).

When claimant was unwilling to enter into a CDA, her counsel contacted Judge Lowe. Noting that he intended to petition the Board for approval of the $10,000 settlement, counsel sought the judge's opinion concerning whether the offer was reasonable. In response, Judge Lowe stated that "I am not only convinced that the settlement offered was a reasonable one, but a highly favorable one to your client, particularly given the contingencies of liability."

Thereafter, claimant petitioned the Board for resolution of these disputes. She requests Board approval of the $10,000 settlement and a distribution in which Allstate receives reimbursement of its PIP lien. Claimant also challenges that portion of Reliance's lien which pertains to the IME. ($1,060). Reliance is prepared to approve the settlement, provided that the proceeds are distributed in accordance with the statutory scheme set forth in ORS 656.593(1).

## FINDINGS OF ULTIMATE FACT

The third party settlement offer of $10,000 is reasonable. A distribution of settlement proceeds in which Reliance recovers $4,005.65 is "just and proper." See ORS 656.593(3).

## CONCLUSIONS OF LAW

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. See Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

After reviewing the parties' respective positions, as well as the record (particularly the FNH's medical report and Judge Lowe's letter), and considering the aforementioned standard, we conclude that a settlement offer of $10,000 is reasonable. Consequently, the settlement is approved. ORS 656.587.

Finally, we turn to a just and proper distribution of the third party settlement proceeds. ORS 656.593(3). The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). We take such an approach 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).

Here, claimant is seeking an alteration of that general approach. Specifically, she is advancing a distribution in which the first $2,620.80 of the $10,000 settlement be allocated to Allstate as reimbursement for its "PIP" lien. Yet, Allstate is not a paying agency since it is not the workers' compensation insurer who paid benefits to claimant resulting from her compensable injury. See ORS 656.576; 656.005(14).

Inasmuch as the statutory scheme for distribution of a third party recovery expressly describes three entities as proceeds' recipients (claimant, claimant's attorney, and the paying agency), we are without authority to direct the payment of a share of settlement proceeds to a fourth entity (claimant's private carrier). See Manuel A. Ybarra, 43 Van Natta 376 (1991); Steven B. Lubitz, 40 Van Natta 450, 452 (1988) (Statutory scheme does not provide for the distribution of any portion of third party recovery directly to physician, medical services provider, or any entity other than claimant, claimant's attorney, and paying agency).

Since Allstate is not an entity who may directly receive a portion of the third party recovery, claimant is essentially promoting an allocation in which she receives a larger share of the recovery (at the expense of the paying agency's share) so that she can then provide reimbursement from her share to that private carrier. We have consistently rejected any approach which strays from the statutory scheme because we believe it would inevitably lead to results that were random, standardless, and, inequitable. John C. Adams, 40 Van Natta 1794 (1988), aff'd mem Liberty Northwest v. Adams, 97 Or App 587 (1989); William C. Smith, 40 Van Natta 1259 (1988).

As the prosecutor of her third party action, claimant is aware of the potential weaknesses of her case, as well as the statutory distribution scheme and her lienholders. Considering this accessability to vital factual information and relevant statutory prerequisites, claimant is in the best position to make an informed and reasoned decision regarding the appropriateness of a settlement offer. Moreover, with that knowledge, claimant has the capacity to accurately calculate what her eventual net recovery will be should she accept such an offer.

Here, in support of her contention that Reliance should have granted its approval, claimant asserts that a $10,000 settlement offer is reasonable. Since we have agreed with claimant's assertion, it follows that claimant must also accept the consequences which naturally flow from such a conclusion. One of those consequences is the distribution of settlement proceeds in accordance with the statutory scheme for third party judgments.

In conclusion, based on the foregoing reasoning, we find no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1). Consequently, we proceed with a distribution of settlement proceeds.

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency is entitled to retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical, or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other cost of the worker's claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), and (c).

Here, claimant's attorney is seeking an attorney fee equal to 1/3 of the remaining balance of settlement proceeds after Allstate receives its "PIP" reimbursement. Since we have concluded that Allstate is not entitled to a direct share of the proceeds, claimant's attorney would be entitled to no more than 1/3 of the $10,000 settlement ($3,333.33). (In reaching this conclusion, we wish to emphasize that we are not holding that claimant's attorney is required to recover that amount in fees; rather, we are stating that this sum is the maximum fee to which claimant's counsel is statutorily entitled). Claimant's attorney is also entitled to the recovery of $658.19 in litigation costs.

Assuming that claimant's attorney's fee is $3,333.33, the remaining balance of settlement proceeds after the deduction of fees and litigation costs equals $6,008.48. As her statutory 1/3 share, claimant is entitled to $2,002.83. (This share would correspondingly increase in proportion to any reduction in claimant's 1/3 attorney's fee). The deduction of claimant's share leaves a remaining balance of $4,005.65.

Reliance's lien totals $7,015.41. The only portion of the lien to which claimant objects is the $1,060 charge for the IME. In defense of this charge, Reliance asserts that it "was necessary to gain control of the medical services." This characterization of the exam is consistent with our conclusion that the IME report was generated for "claim evaluation" purposes. It is well-settled that expenditures for such reports cannot be included in a paying agency's lien. David G. Payne, 43 Van Natta 918 (1991); Carolyn G. Gant, 39 Van Natta 471 (1987); Darrell L. Rambeau, 38 Van Natta 144 (1986).

Notwithstanding the reduction of its lien by the aforementioned $1,060 IME expense, the remainder of Reliance's lien exceeds the $4,005.65 remaining balance of settlement proceeds. Consequently, Reliance is entitled to that balance.

Accordingly, assuming that claimant's attorney's fee equals the maximum fee described above, the settlement proceeds shall be distributed in the following manner:

| | |
|---|---|
| Settlement | $10,000.00 |
| 1/3 Attorney Fee | - 3,333.33 |
| Subtotal | $ 6,666.67 |
| Litigation Costs | - 658.19 |
| Subtotal | $ 6,008.48 |
| Claimant's 1/3 Share | - 2,002.83 |
| Remaining Balance (Reliance's Share) | $ 4,005.65 |

Claimant's attorney is directed to distribute the settlement proceeds in accordance with this order.

IT IS SO ORDERED.

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January 8, 1993 Cite as 45 Van Natta 24 (1993)

In the Matter of the Compensation of
**JUDY A. JACOBSON, Claimant**
WCB Case No. 91-16843
ORDER OF ABATEMENT
Goldberg & Mechanic, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The insurer requests reconsideration of our December 1, 1992 Order on Review as reconsidered on December 16, 1992.

In order to consider the insurer's motion, we withdraw our December 1, 1992 Order on Review and December 16, 1992 Order on Reconsideration. Claimant is granted an opportunity to submit a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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January 8, 1993 Cite as 45 Van Natta 24 (1993)

In the Matter of the Compensation of
**ROGER LAMMI, Claimant**
Own Motion No. 92-0449M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Richard McGinty, Claimant Attorney
Charles Lundeen, Defense Attorney

The insurer has submitted to the Board claimant's claim for an alleged worsening of his May 3, 1984 injury, which included an injury to his right thumb. Claimant's aggravation rights expired on January 13, 1992. On July 14, 1992, claimant underwent surgery to his right thumb. On August 18, 1992, the insurer voluntarily reopened claimant's claim and requested reimbursement from the fund. Claimant contends that he made an aggravation claim prior to the expiration of his aggravation rights. He also contends that, in an April 23, 1992 letter, the insurer accepted claimant's aggravation claim in return for claimant's withdrawing a hearing request on the "de facto" denial of his aggravation claim. In effect, claimant's second contention is an equitable estoppel argument. We defer our decision as to whether this case is within our own motion jurisdiction pending a fact-finding hearing.

If claimant files a claim for a worsening of a compensable injury after the expiration of his aggravation rights, the claim is exclusively within the Board's own motion jurisdiction. See ORS 656.278; Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Robin S. Masse, 42 Van Natta 1832 (1990); Derek Oliver, 42 Van Natta 1972 (1990). If, however, the claim for worsening is filed before expiration of aggravation rights, the Board lacks own motion jurisdiction and the claim must, instead, be processed as an aggravation claim under ORS 656.273.

Here, the record contains some indication that claimant may have filed a claim for a worsened condition before the expiration of his aggravation rights. In addition, there is some indication that the insurer may have agreed to process claimant's condition as an aggravation. Thus, the insurer may be equitably estopped from denying the aggravation claim. We note that the principle of equitable estoppel may be applicable against an insurer (or self-insured employer) in a workers' compensation setting if all the elements of estoppel are met. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992); Lamarr H. Barber, 43 Van Natta 292 (1991).

Because the facts of this case presented a question as to whether this matter is properly within the Board's own motion jurisdiction, we requested the parties to submit their respective positions to several questions involving the significance of the insurer's April 23, 1992 letter and whether the July 1992 surgery was for the same worsened condition referenced in Dr. Russell's October 1991 letter. We have received the parties' responses to our questions; however, we find these responses inadequate to resolve the jurisdictional issue before us. Therefore, we conclude that the most expedient manner in which to resolve this matter is to refer it to the Hearings Division for findings of fact and a recommendation.

Accordingly, this matter is referred to the Presiding Referee with instructions to assign a Referee to perform a fact finding hearing. At the hearing, the assigned Referee shall take evidence on the questions of whether: (1) claimant perfected an aggravation claim before his aggravation rights expired on January 13, 1992; and (2) the insurer is equitably estopped from denying an aggravation claim. This hearing may be conducted in any manner that the Referee determines will achieve substantial justice. Following the hearing, the Referee shall issue a recommendation to the Board within 30 days. In that recommendation, the Referee shall make findings of fact on the questions of whether claimant perfected an aggravation claim before his aggravation rights expired, and whether the insurer is equitably estopped from denying claimant's aggravation claim. Based on those findings of fact, the Referee shall recommend to the Board whether it should order the claim reopened under own motion jurisdiction.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RITO N. NUNEZ, Claimant**
WCB Case Nos. 91-10770, 91-17477, 91-16978 & 91-17476
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Marcia Barton (Saif), Defense Attorney
Kevin Mannix, PC, Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of those portions of Arbitrator McWilliams' decision which: (1) set aside its denial of claimant's "new injury" claim for a right hip condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility.

Reviewing for questions of law pursuant to ORS 656.307(5), we affirm and adopt the Arbitrator's decision with the following comment.

Relying on our decision in Rosalie S. Drews, 44 Van Natta 36 (1992), the Arbitrator found that Liberty had carried its burden of establishing that claimant sustained a new injury during the period that SAIF was on the risk. Therefore, she concluded that SAIF was the responsible carrier.

SAIF first contends on review that the Arbitrator misapplied our responsibility analysis in Drews. It argues that, in determining whether claimant sustained a "new injury," the Arbitrator erred in failing to analyze whether claimant had sustained a pathological worsening of his condition. However, claimant here alleged, and we agree, that his condition was the result of an injury, not an

occupational disease. Consequently, in order to establish a new injury, Liberty need only show that claimant's 1991 injury while SAIF was on the risk was a material contributing cause of claimant's disability or need for treatment. Liberty need not show a pathological worsening of the condition to prove a new injury. See Mark N. Wiedle, 43 Van Natta 855 (1991); compare Donald C. Moon, 43 Van Natta 2595 (1991) (Claimant did not sustain a new occupational disease because his work activity with Liberty's insured did not cause a pathological worsening of his initial injury).

SAIF further contends that claimant's 1988 injury, while Liberty was on the risk, amounted to a "preexisting condition" for purposes of ORS 656.005(7)(a)(B), and therefore, Drews was wrongly decided and the Arbitrator should have applied the major contributing cause standard, instead of a material contributing cause standard. However, we have already rejected that argument in Ronald L. Rushton, 44 Van Natta 124 (1992).

Claimant has submitted a respondent's brief on review. However, compensability was not litigated at hearing and there is no evidence that claimant's compensation would have been reduced if responsibility had remained with Liberty. (In fact, claimant's TTD rate under the SAIF claim is less than it would be under the Liberty claim. Ex. 22). Because claimant's compensation was not at risk of disallowance or reduction, claimant's attorney is not entitled to an attorney fee for services on Board review. See ORS 656.382(2); Long v. Continental Can Co., 112 Or App 329 (1992); Riley E. Lott, 43 Van Natta 209, 212 (1991).

ORDER

The Arbitrator's decision dated April 30, 1992 is affirmed.

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January 8, 1993 Cite as 45 Van Natta 26 (1993)

In the Matter of the Compensation of
**FLORENCE L. SCOTT, Claimant**
WCB Case No. 91-17703
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

The self-insured employer requests reconsideration of our December 16, 1992 Order on Review that affirmed a Referee's order that: (1) set aside its partial denial of claimant's right radial nerve condition; and (2) set aside its denial of claimant's request for surgery. The employer also contends that the total attorney fee awarded for claimant's counsel's services at hearing and on review was excessive.

In order to consider the employer's motion, we withdraw our December 16, 1992 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**TONY E. ALFANO, Claimant**
Own Motion No. 87-0237M
OWN MOTION ORDER OF ABATEMENT
Royce, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of our December 14, 1992 Own Motion Order in which we set aside the employer's Notice of Closure and remanded claimant's claim to the employer for further processing to closure pursuant to ORS 656.268. We based our decision, in part, on Carter v. SAIF, 52 Or App 1027 (1981), and Coombs v. SAIF, 39 Or App 293 (1979). The employer argues that these cases are distinguishable. Specifically, it argues that these cases, in effect, preserve claimant's right to appeal the final determination of his permanent disability. However, it argues that there is no need to preserve this right in the present case because claimant actually appealed his final determination of permanent disability, although he later withdrew that appeal. Thus, it argues, the Notice of Closure properly closed claimant's claim pursuant to ORS 656.278.

In order to allow sufficient time to consider the employer's motion, the above-noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GERALD K. HALE, Claimant**
WCB Case No. 90-07637
ORDER ON REVIEW
Parks & Ratliff, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Fink's order that upheld the SAIF Corporation's denial insofar as it denied claimant's left shoulder injury claim. On review, the issue is compensability. We reverse.

On March 29, 1991, the Referee found that, as of the date of hearing, all diagnostic procedures performed on claimant's left shoulder had failed to reveal the cause of his symptoms. Thus, the Referee concluded that claimant had not proven the compensability of his left shoulder condition. Thereafter, claimant requested Board review.

On review, claimant submitted copies of post-hearing operative reports. On August 26, 1992, we remanded this matter to the Presiding Referee with instructions to appoint a referee to reopen the record for admission of additional evidence regarding claimant's post-hearing surgeries. See Gerald K. Hale, 44 Van Natta 1678 (1992). The appointed Referee was directed to provide an Order on Remand explaining the effect, if any, the additional evidence had upon the decision rendered in the prior proceeding.

On November 23, 1992, Referee Baker issued an order in accordance with our instructions on remand. The Referee admitted into evidence the June 3, 1991 operative report of claimant's treating surgeon, Dr. MacCloskey, M.D., as Exhibit R-1, and the doctor's November 18, 1991 operative report as Exhibit R-2. SAIF waived its right to cross-examine Dr. MacCloskey or to submit rebuttal evidence. Based upon those exhibits, the Referee found that the additional evidence provided that: (1) at surgery, claimant had a left shoulder outlet impingement, and a smashed and torn biceps tendon; and (2) the expert medical opinion reported that the surgical findings were consistent with the injury described by claimant. Thus, the Referee concluded that the effect of the additional evidence upon the prior order was to remove the principal basis relied upon by the prior referee, i.e., that the medical evidence did not reveal a cause of or reason for claimant's alleged increased symptomology.

Having received the Order on Remand, we proceed with our review. 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. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Claimant's disability or need for treatment is compensable if the industrial injury is a material contributing factor in its causation. Julie K. Gasperino, 43 Van Natta 1151 (1991) aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark Wiedle, 43 Van Natta 855 (1991).

For the reasons discussed in our previous order, we continue to find claimant credible. The prior Referee's credibility finding was based upon perceived inconsistencies in the medical reports and testimony, rather than claimant's demeanor. We therefore find that we are in as good a position as the prior Referee to evaluate the documentary record. Afer our de novo evaluation, we decline to defer to the prior Referee's credibility finding. Rather, we find claimant's reporting of his injury and its symptoms to be consistent with the remainder of the record.

We conclude that claimant has established that the November 16, 1989 incident was a material contributing cause of his left shoulder condition and need for medical treatment. In the June 3, 1991 operative report, Dr. MacCloskey diagnosed claimant's condition as an outlet impingement with a torn biceps tendon. (Ex. R-1). Dr. MacCloskey further reported that: "The findings in the shoulder were consistent with an injury as the patient describes." (Ex. R-1). As claimant's surgeon, we find Dr. MacCloskey's observations and assessments to be persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Moreover, we conclude that Dr. MacCloskey's operative report and medical opinion establishes claimant's injury by medical evidence supported by objective findings. Accordingly, we hold that claimant has established a compensable injury.

For prevailing on the issue of compensability, claimant's counsel is entitled to an assessed attorney 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 assessed fee for claimant's counsel's services at hearing and on Board review is $2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and appellant's brief on review), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

## ORDER

The Referee's order dated March 29, 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 concerning the compensability issue, claimant's counsel is awarded an assessed fee of $2,500, payable by SAIF.

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In the Matter of the Compensation of
**THERESA A. ADAMS, Claimant**
WCB Case No. 91-15929
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Crumme's order that upheld the self-insured employer's partial denial of claimant's occupational disease claim for a right shoulder and neck 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 last sentence in paragraph 8 and paragraph 9, and with the following supplementation.

Beginning in about 1989, claimant experienced progressive symptoms of pain and numbness in both hands. (Ex. 10).

Claimant received physical therapy and other conservative treatment between January 22, 1991 (not April 1991) and July 15, 1991, for both carpal tunnel and neck and right shoulder symptoms.

The employer accepted claimant's bilateral carpal tunnel syndrome as an industrial injury. (Ex. 41).

The employer issued a partial denial of claimant's neck and right shoulder conditions as unrelated to claimant's accepted industrial injury. (Ex. 41).

## FINDINGS OF ULTIMATE FACT

Claimant's work activities for the employer were the major contributing cause of her current need for treatment for a right shoulder and neck condition. This condition was established by medical evidence supported by objective findings.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's right shoulder and neck condition was not compensable as an occupational disease, because she had no pathological worsening of her underlying condition, or as a consequence of her accepted injury.

Claimant contends that the lay and medical evidence establish that work activities and the bilateral carpal tunnel condition are the major contributing cause of her right shoulder and neck condition, and that she did not have a preexisting condition, as she did not experience neck and right shoulder symptoms until April 1991.

The employer contends that the medical evidence shows that claimant had right shoulder and neck pain since January 1991, in direct conflict with her testimony that the pain did not arise until April 1991, thus raising the issue of her credibility. It further contends that the accepted carpal tunnel syndrome is not the major contributing cause of claimant's current neck and right shoulder condition.

The Referee made no credibility findings. However, we are equally capable of assessing credibility based on an objective evaluation of the documentary evidence and claimant's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Here, claimant testified that her shoulders got sore from working, but not to the point where she would seek "treatment" for it. (Tr. 8). Claimant first saw a doctor for her shoulder complaints in May 1991. In January 1991, she had complained of right neck and shoulder pain to a physical therapist, who requested authorization to treat the shoulder as well as claimant's wrists. (Ex. 8-1). In April, 1991, claimant continued to complain of pain in the right neck, upper trapezius and shoulder to her physical therapist, although she did not report such symptoms to Dr. Ahbel. (Exs. 19 and 21). In his May 1991 evaluation, Dr. Pribnow reported that over the last 18 months claimant had been progressively more aware of some degree of pain and stiffness in her neck and right shoulder, which, over the last several months had been greater than the symptoms in the right arm. He tentatively diagnosed a myofascial pain disorder in the neck and shoulder, which he treated with injections.

We assume that claimant took the word "treatment" to mean treatment from a medical doctor. Accordingly, we do not find claimant's testimony to contradict the remaining evidence. In any event, we rely primarily on the medical evidence to establish causation in this case.

Under ORS 656.802(2), claimant has the burden to prove that her employment conditions were the major contributing cause of the disease or its worsening. In addition, the existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2). A "major contributing cause" means an activity or exposure or combination of activities or exposures which contribute more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983).

The existence of claimant's shoulder condition is supported by objective findings. Dr. Pribnow found tenderness of the right rhomboid, the anterior right shoulder, a tender trigger point in the trapezius, and muscle spasm in the right cervical paraspinal muscles. (Exs. 23 and 31A).

The Referee found that claimant must prove that her employment was the major contributing cause of a pathological worsening of a preexisting condition. We disagree with the Referee's characterization. Claimant experienced no injury to her shoulder. She sought no medical treatment for her shoulder until a year after she began work with the employer. There is no evidence of a significant contribution to her shoulder condition from off-work activities or congenital abnormalities. We do not find that Dr. Jacobs' June 10, 1991 report that claimant had been aware of pain and stiffness in her neck and shoulder for "the past 18 months" sufficient to establish that claimant had a disease that preexisted her employment. Under such circumstances, claimant's condition cannot be termed "preexisting." Furthermore, the accepted carpal tunnel syndrome injury also cannot be categorized as "preexisting." See Rosalie S. Drews, 44 Van Natta 36 (1992).

Claimant's work consists of lifting stock and carrying merchandise. Dr. Jacobs diagnosed claimant's condition as a myofascial pain disorder. He theorized that the hand symptoms may have caused a protective type of muscle tension guarding in the neck and shoulder area, which resulted in some related chronic muscle tension and symptomatology. (Ex. 31A-2). He later changed to his diagnosis to myofascial pain in the neck and shoulder aggravated by insufficient strength. Dr. Rosenbaum, neurosurgeon, who performed an independent medical evaluation, diagnosed overuse syndrome of the upper extremities. He opined that claimant's neck and shoulder complaints were only indirectly related to the carpal tunnel syndrome, but were directly related to her occupation.

We find Dr. Jacobs' varying opinions to be less persuasive than that of Dr. Rosenbaum, which relied on an examination and medical record review. See Weiland v. SAIF, 64 Or App 810 (1991). In rendering his opinion, Dr. Rosenbaum did not quantify the degree of causation by indicating that the work exposure, including the compensable carpal tunnel injury, was the major contributing cause of the myofascial pain in the neck and shoulder. However, the use of "magic words" or statutory language is not required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Based on the record as a whole, we find that claimant has established a compensable occupational disease.

Because we have concluded that claimant's shoulder and trapezius condition is a compensable occupational disease, we decline to address the issue of whether her condition is compensable as a consequence of the accepted carpal tunnel injury.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,000, 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 appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated March 11, 1992 is reversed. The self-insured employer's denial of claimant's right shoulder and neck condition is set aside and the claim remanded to the employer for processing according to law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
**KENT D. ANDERSON, Claimant**
WCB Case No. 92-00646
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brazeau's order that increased his scheduled permanent disability award from 13 percent (19.5 degrees), as awarded by Order on Reconsideration, to 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of his right hand. On review, the issue is extent of scheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant's doctor did not relate his grip strength loss to nerve damage, claimant was not entitled to an award under the Director's "standards" for rating disability. We disagree.

The "standards" in effect at the time of the November 4, 1991 Notice of Closure provide, in part, that loss of strength is rated when the cause is a peripheral nerve injury and the value of impairment is determined based upon the specific nerve affected. OAR 436-35-110(2)[1]. However, OAR 436-35-110(2)(a) further provides that loss of strength due to loss of muscle or disruption of the musculotendonous unit "shall be valued as if the nerve supplying that muscle or muscle group were impaired." Accordingly, claimant argues that the applicable standards provide an award even if there is no nerve injury, as long as it is proven that the loss of strength is due to loss of muscle or disruption of the musculotendonous unit. We agree.

Here, Dr. Jewell, claimant's treating doctor, found that claimant's loss of grip strength was not necessarily related to any type of nerve damage. However, Dr. Jewell related claimant's loss of grip strength directly to the industrial accident "and the mobilization (sic) which occurred during both the first and second surgeries." Dr. Jewell also related the lost grip strength to "post traumatic scarring involving the extensor tendon." (Ex. 11).

We conclude that Dr. Jewell's report establishes that claimant's loss of strength is due to disruption of the musculotendonous unit. Also see Ex. 5. Accordingly, we agree that the Order on Reconsideration properly awarded a grip strength value of 51 percent pursuant to OAR 436-35-110(2). Therefore, claimant's value for loss of grip strength, 51 percent, is modified by OAR 436-35-007(14) and claimant is entitled to a value of 10 percent for lost grip strength. When that value is combined with claimant's existing award of 25 percent, the result is a total of 33 percent scheduled permanent disability.

## ORDER

The Referee's order dated April 13, 1992 is modified. In addition to the Referee and Order on Reconsideration awards totalling 25 percent (37.5 degrees), claimant is awarded 8 percent (12 degrees) scheduled permanent disability for a total award to date of 33 percent (49.5 degrees) scheduled permanent disability for loss of use or function of his right hand. Claimant's counsel is awarded 25 percent of the additional compensation created by this order, payable directly to claimant's attorney. However, the total out-of-compensation fees awarded under the Referee and Board orders shall not exceed $3,800.

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[1] We note that, prior to the standards applied in this case (WCD Admin. Order 2-1991), grip strength was ratable under the standards only if it could be attributed to nerve damage, atrophy, or other anatomical changes. See former OAR 436-35-110(3); Martha L. Brunner, 42 Van Natta 2582 (1990).

In the Matter of the Compensation of
**DARLENE L. BARTZ, Claimant**
WCB Case No. 91-14942
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

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

## FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his "Findings of Ultimate Fact," with the following supplementation.

## FINDING OF ULTIMATE FACT

Claimant's repetitive work activities for the employer were the major cause of her bilateral CTS condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to prove that her work activities were the major contributing cause of her CTS condition or its worsening. In reaching this result, the Referee found the opinion of Dr. Nathan, independent examiner, more persuasive than the opinion of Dr. Thayer, treating orthopedist. We disagree.

We generally defer to the opinion of an injured worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons.

It is undisputed that claimant has bilateral CTS and that her work for the employer involved wrist activities of a type expected to at least cause claimant's symptoms. (See Ex. 6-5). The question is whether claimant's work exposure was the major contributing cause of her bilateral CTS disease or its worsening. ORS 656.802(1)(c); ORS 656.802(2). More specifically, because there is no persuasive evidence that claimant's CTS preexisted her work for the employer, the issue is whether her work was the major contributing cause of her disease.

Claimant sought treatment for hand pain occasionally between 1985 and 1988. (Ex. AA). Osteoarthritis was the suspected cause of claimant's symptoms initially, until CTS was mentioned in 1988. (Id). Claimant filed a claim for bilateral wrist pain in July, 1991 and CTS was unequivocally diagnosed thereafter. (Exs. 1 & 2A).

Claimant sought treatment from Dr. Carroll, who recorded claimant's history of working "for ten years at a mill job operating cut off saws, amongst other things." (Ex. 3A). Carroll also reported claimant's long history of arm pain and finger numbness, with recent increased discomfort. Carroll recommended that claimant "start looking for less demanding work." (Id.; see Ex. 4A).

Dr. Thayer examined claimant in August 1991 and noted her history of over ten years of mill work, as well as her symptoms and CTS diagnosis. (Ex. 4-1). Thayer opined, "Certainly lighter work would be helpful[.]" (Id). By October 1991, Thayer was claimant's treating physician. He stated, "Once again, the history obtained is that she does very heavy work lifting boards that weigh up to 20 pounds. This has been going on somewhere between eight and eleven years." (Ex. 9). Based on claimant's job description, symptoms and examinations, Thayer opined that the "51% rule would apply and this is a compensable injury." (Id).

The only evidence contrary to Thayer's opinion regarding causation comes from Dr. Nathan, independent examiner. Considering the severity of claimant's condition and her age, 58, Nathan opined that claimant's CTS was a "long-term process," intrinsic to claimant, rather than caused by her work. Although Nathan opined that claimant's CTS took many years to develop, he did not explain why he believed that her age and build are more significant than her eleven year exposure to mill work. Instead, Nathan stated that studies indicate that personal characteristics, such as age and build, are more likely causes than are activities. In other words, Nathan opined that claimant fits the profile of a person likely to get CTS, regardless of her work. Because Nathan relied on studies which do not involve claimant and discounted claimant's extensive work exposure without further explanation, we find his opinion concerning claimant to be insufficiently explained. As such, it is not particularly persuasive. See Somers v. SAIF 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Finally, we note the Referee's stated inability to discern whether Dr. Thayer believes that claimant's work was the major cause of her condition, or merely of her symptoms. Thayer operated on claimant's right wrist to repair its entrapment neuropathy, (see Ex. 11), and opined that claimant's work caused her need for treatment. Under these circumstances, we interpret Dr. Thayer's opinion concerning the etiology of claimant's CTS to apply to her disease as well as her symptoms.

In summary, we find no reason to discount the opinion of Dr. Thayer. That opinion is based on an accurate history and numerous opportunities to examine and treat claimant. In addition, Thayer's opinion is supported by Carroll's recommendations that claimant change jobs. On this evidence, we find that claimant has proven that her work activities for the employer were the major cause of her bilateral CTS disease. Accordingly, the claim is compensable. See Liberty Northwest Ins. Corp. V. Cross, 109 Or App 109 (1991)(No incantation of "magic words" or statutory language is required).

Claimant is entitled to an assessed attorney fee for prevailing on compensability issue. 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 issue is $3,500, 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated April 27, 1992 is reversed in part and affirmed in part. The self-insured employer's denial of claimant's bilateral carpal tunnel syndrome condition is set aside. That claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,500, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**DEBRA L. GODELL, Claimant**
WCB Case No. 92-00710
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability benefits for a low back strain. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant argues that the Referee erred in declining to adopt the impairment finding of her attending physician. We disagree.

ORS 656.245(3)(b)(B) provides, in relevant part:

> "Except 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."

ORS 656.726(3)(f) authorizes the Director to provide standards for the evaluation of disabilities. Under those standards, ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings."

The apparent conflict between ORS 656.245(3)(b)(B) and 656.726(3)(f)(B) is reconciled by OAR 436-35-007(9), which provides that "[i]mpairment is determined by the attending physician except where a preponderance of medical opinion establishes a different level of impairment."

Thus, although an attending physician's findings are generally relied upon in evaluating the worker's permanent disability, we do not adopt such findings if a preponderance of the medical evidence undercuts the reliability of those findings. See, e.g., Kristen A. Hart, 44 Van Natta 885 (1992); Arlene J. Koitzsch, 44 Van Natta 776 (1992).

Here, we conclude that a preponderance of the medical evidence weighs against the attending physician's finding that claimant has sustained a permanent impairment. Dr. Leopold, the attending physician, concurred with the Orthopaedic Consultants' June 6, 1991 report. (Ex. 18). In that report, Drs. Gambee and Watson found, contrary to claimant's complaints, no permanent residual of the compensable injury. (Ex. 15). They found, instead, marked functional overlay manifested by pain posturing, non-compliance and "true interference" with the examination. (Id).

Four months after her concurrence, Dr. Leopold wrote in response to claimant's attorney's inquiry:

> "I feel that [claimant] has some limited range of motion with moderate pain in her low back area that will become a chronic low back condition and limit her ability to engage in activities requiring medium to moderate repetitive use of her back." (Ex. 19C).

Based on this report, claimant argues that she has proved a chronic condition impairment which prevents repetitive use of the back. See OAR 436-35-320(5). We disagree for the following reasons.

Leopold's report does not offer any explanation for the change in her opinion. Nor does the report address claimant's well-documented functional behavior, which has interfered with the examinations by both the Orthopaedic Consultants and Drs. Bolton and Reimer at First Northwest Health. (See Exs. 10, 14, 15). Finally, Leopold states that claimant's condition "will become a chronic

low back condition," thereby anticipating a future condition. Inasmuch as a chronic condition impairment must be based on a current disability, we do not find Leopold's opinion to be persuasive evidence of a permanent impairment.

ORDER

The Referee's order dated April 10, 1992 is affirmed.

**Board Member Hooton dissenting.**

Claimant argues that the language of ORS 656.245(3)(b)(B) is clear and unambiguous and requires that impairment findings used in the rating of disability be adopted only from the reports of the treating physician. The majority argues that ORS 656.245(3)(b)(B) can and must be construed in a manner consistent with ORS 656.726(3)(f)(B). It argues that OAR 436-35-007(9) properly construes both statutes and resolved any apparent conflict between them.

Permanent partial disability compensation is compensation to which claimant is entitled, as the result of a legislative enactment, assuming, of course, that permanent disability is shown to exist deriving from a compensable injury. Because the right to permanent disability compensation is a matter of statutory entitlement, due process requires the right of the parties to a hearing regarding the amount due. Carr v. SAIF 65 Or App 110 (1983). The right to a hearing is meaningless without the right to prepare and present evidence bearing upon the question at issue, to challenge the credibility and reliability of evidence presented by the adverse party, and generally to pursue its interests in the matter at issue.

While there is substantial evidence in the legislative history which supports the notion that the legislature intended to deprive the insurer of the right to obtain IME reports regarding impairment and therefore to eliminate the battle of the medical experts in workers' compensation proceedings such an intent would be contrary to the constitutional requirements of due process. I will not, therefore, attribute such an intent to the legislature.

Rather, I read ORS 656.245(3)(b)(B) as creating a rebuttable presumption that the findings of the treating physician are correct. In order to establish impairment by findings other than those made by the treating physician, the insurer/employer must first demonstrate by a preponderance of the evidence that the findings of the treating physician are unreliable. This approach is consistent with the statute and with prior Board precedent. See e.g. Kristen A. Hart, 44 Van Natta 885 (1992); Arlene J. Koitzsch, 44 Van Natta 776 (1992).

Turning to the evidence in the present dispute, I would find that the insurer has not rebutted that presumption and that claimant is entitled to have her impairment established based on the findings of her treating physician.

The medical evidence in the current record comes from essentially five sources. I will consider each in turn.

On April 1, 1991, claimant was examined by Drs. Bolton and Reimer of First Northwest Health. The examination was an independent medical examination conducted at the request of the insurer. The examination revealed marked restrictions in cervical and lumbar ranges of motion but concluded that these findings were attributable to functional behaviors giving rise to the inference that psychological factors may be interfering with claimant's recovery. The basis for this inference is evident in the finding that there is no objective evidence of orthopedic or neurological abnormality. (Ex. 10). This report is disputed by the treating physician who declined to concur, relying on the report of consulting physician Lawrence Franks, M.D., and findings of his examination as objective evidence of an orthopedic condition requiring treatment.

As a part of the consulting examination performed by Dr. Franks, claimant received a limited bone scan of the lumbar spine and pelvis. The results of this examination were interpreted by Brian L. Dunkley, M.D., who found genuinely objective, and on this record uncontradicted, evidence of bilateral sacroiliitis. (Ex. 11). In light of the findings of Dr. Dunkley, the weigt to be afforded the report and

conclusions of First Northwest Health are substantially reduced. That report is based on the erroneous conclusion that there is no objective evidence of orthopedic disease.

On June 6, 1991, claimant was again examined at the request of the insurer, though this time by Drs. Gambee and Watson of the Orthopaedic Consultants, P.C. In addition, claimant received a psychological examination by Grant Hughes, M.D. The Orthopaedic Consultants' examination acknowledged the findings of the bone scan, noted significantly reduced ranges of motion, noted grade two pain behavior and grade three interference. The report comments in conclusory fashion without explanation that "of course" claimant's sacroiliitis is unrelated to the industrial injury. (Ex. 15-5). The report does not directly comment on the likelihood of psychological factors interfering with the recovery process, but by reference to the reports of First Northwest Health and Dr. Hughes, clearly implies such a relationship. The report does not find that claimant is medically stationary, but recommends claim closure and the discontinuation of any further medical therapy for psychological reasons. They argue that discontinuations of therapy and a prompt return to the workplace will positively impact claimant's self image of being disable. This suggests the efficacy of occupational placement and the lack of further medical support as a form of treatment in and of itself that will produce an improved condition. The conclusion that occupational placement is a form of therapy is further supported by the notation that claimant's initial return to the workforce should be in an occupation other than her work at the time of injury, an occupation to which she is physically unsuited, and with initial sheltering. Consequently, the report, taken in its entirety, does not support a finding that claimant is medically stationary, but, rather, is strong evidence to the contrary. The recommendations regarding claim closure are statutorily impossible since claimant's claim cannot be closed simply to advance therapeutic interests as a form of treatment. Claim closure is not statutorily permissable until a medically stationary status is achieved.

Dr. Hughes identifies two conditions, recognized in the psychological community, contributing to claimant's presentation. These are adjustment disorder with mixed emotional features, and psychogenic pain disorder. In the body of his report, Dr. Hughes attributes changes in the level of functioning to financial limitation, continuance of unemployment, physical pains, and stress at home. It is interesting to note that he finds no evidence of personality disorder and each of the stressful factors identified as causally related are directly traceable to claimant's compensable injury. (Ex. 14-5). While he includes the reference that claimant's adjustment disorder is considered cyclic and recurring based on history, there is no evidence in the history reported that claimant has ever experienced like problems in the past. Dr. Hughes clearly relates claimant's functional behavior on examination and interferences to the two diagnosed conditions.

Dr. Hughes also defers to the physical examiners at the Orthopaedic Consultants for the determination of claimant's medically stationary status, despite the fact that he indicates that claimant's psychological functioning is expected to improve with the passage of time. (Ex. 1406).

On June 11, 1991, the insurer officially accepted claimant's claim though that acceptance was limited to lumbar strain. No denial has issued for claimant's sacroiliitis or congenital scoliosis. The insurer has neither accepted or denied claimant's adjustment disorder and psychogenic pain disorder. (Ex. 17).

On July 19, 1991, Dr. Leopold, claimant's treating physician, concurred with the report of the Orthopaedic Consultants without comment. (Ex. 18).

On June 10, 1991, the insurer solicited and received a report from James B. Eubanks, Sr., D.O., a prior treating physician, who noted that he had last seen claimant on February 27, 1991, and at that time diagnosed chronic low back pain. He indicated that claimant was medically stationary on February 27, 1991, but that determination appears to be based on claimant's failure to return for additional therapy recommended at the time of the exam. Dr. Eubanks is unfamiliar with the course of claimant's condition or treatment after February 27, 1991. Consequently, his report is of little relevance in the determination of status or impairment. (Ex. 16).

On July 30, 1991, the insurer closed the claim with no award of permanent partial disability, alleging that claimant had become medically stationary on June 6, 1991, the date of her examination with the Orthopaedic Consultants. (Ex. 19).

On November 25, 1991, claimant's treating physician entered a delayed report indicating that claimant had physical impairment related to her industrial injury. She identified loss of range of motion and chronic low back symptoms limiting claimant's capacity to perform medium to moderate repetitive activity. She further indicated that claimant was asymptomatic from her congenital back disorder prior to the injury, but her previously asymptomatic low back condition had become persistently symptomatic subsequent to her injury. In light of her pre- and post injury conditions, she found it more than probable that the industrial injury "precipitated and caused" her persistent and disabling symptoms. She also identified a stress component that "has exacerbated her perception of pain and injury in her low back area." (Ex. 19C). Dr. Leopold offered no opinion regarding the causation of claimant's "stress component."

On January 14, 1992, an Order on Reconsideration issued affirming the Notice of Closure in all respects.

The majority finds that the treating physician's findings are entitled to little weight because she does not explain the apparent change in her belief between the concurrence letter of July and the report to claimant's counsel in November. In light of the statutory presumption in favor of the findings of the treating physician, I believe that the majority's reasoning is misplaced. The report of the treating physician must be a guide for our judgment, unless the insurer has demonstrated its lack of reliability. On this record, I cannot support that conclusion.

The November report of Dr. Leopold is consistent with her report declining to concur with the findings of First Northwest Health. In addition, the November report is not inconsistent with her concurrence with the report of the Orthopaedic Consultants, except on two points that are largely insignificant. The report of the Orthopaedic Consultants states, without explanation, that claimant's compensable injury did not cause her preexisting low back disease. This conclusion is tautological. It is functionally impossible for a subsequently occurring event to "cause" a preexisting condition. The Orthopaedic Consultants did not address the relationship of claimant's now symptomatic low back disorder to her compensable injury. In her November report, however, Dr. Leopold did examine that relationship and directly and reasonably links claimant's symptomatic low back condition to her industrial injury. That report also examines the relationship between claimant's symptoms and her subsequently arising psychological disorder, and finds, consistent with the report of the Orthopaedic Consultant, that claimant's perception of pain is exacerbated by that psychological disorder. That information, while establishing that it is not improper for Dr. Leopold to concur with the Orthopaedic Consultants is also rendered irrelevant as a basis for denying compensation since the report of Dr. Hughes establishes the compensability of that psychological disorder. The remaining distinction between the reports of the Orthopaedic Consultants and the November report of Dr. Leopold is the conclusion of the Orthopaedic Consultants that claimant suffers no objectively measurable permanent impairment. This distinction is of questionable relevance since Dr. Leopold accepts that claimant's true spinal range of motion is affected by a stress component. Further, claimant does not argue that she is entitled to compensation for lost range of motion, but rather her inability to regularly perform moderately repetitive activities, a limitation that is not discussed by the Orthopaedic Consultants except to note that claimant should not return to her job at injury. The Orthopaedic Consultants did conclude, however, that claimant probably does suffer some minimal loss of range of motion, and it is not, therefore, inconsistent for Dr. Leopold to rely upon that minimal loss as evidence of an inability to perform repetitive activities.

Contributing to a complete weighting of the evidence in the entire record is the consideration that, under the rules currently applied by the Board, whether or not mandated by statute, each of the IME reports suffers some deficiency which diminishes the weight which is should be afforded. The report of the Orthopaedic Consultants is conclusory on important aspects of causation. It also fails to analyze whether claimant's psychogenic pain disorder is responsible for any, or all, of her disability. As a consequence, under the analysis required by Somers v. SAIF, 77 Or App 259 (1986), that report is entitled to little weight.

The report of Dr. Hughes establishes the causal relationship of the psychological diagnosis to claimant's injury, but fails to address the question of disability in light of that relationship. Again, that report is entitled to little weight under Somers.

The reports of First Northwest Health and Dr. Eubanks are based on an incomplete history. Again, those reported are entitled to little weight under the reasoning we have adopted in Somers.

This case is instructive of the damage that results from a review of the evidence presented in the record as separate and distinct wholes, rather than reviewing the evidence all together as a single whole. By discarding evidence as unworthy under the rules, we have adopted from Somers and others, and looking only at the evidence that remains, we are able to reach any desired result, even though the evidence as a whole quite clearly calls for a contrary conclusion.

Because on this record the opinion of the treating physician remains entitled to greater weight, and because that opinion is substantially confirmed by the additional evidence available in the reports of the various IME physicians, I find that the insurer has failed to rebut the presumption created by ORS 656.245(3)(b)(B). I further find that the treating physician's declaration that claimant will suffer a chronic low back condition does not refer to the development of such a condition in the future, but rather, in light of the entire record, that claimant will continue to experience the effects of her chronic low back symptoms. Thus, claimant is entitled to 5 percent unscheduled permanent partial disability for chronic conditions limiting repetitive use of her low back. The fact that a portion of the disability may be psychogenic is irrelevant since the report of Dr. Hughes establishes that claimant's adjustment disorder and psychogenic pain disorder are caused exclusively by stressors arising as a consequence of her compensable injury.

Because I find claimant entitled to an award of 5 percent impairment, she is also entitled to an additional rating for age, education and adaptability for a total award of 35 percent unscheduled permanent partial disability.

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In the Matter of the Compensation of
**ERNIE GOFF, Claimant**
WCB Case No. 91-10107
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee McCullough's order that set aside its partial denial of claimant's claim for right wrist surgery. On review, the issue is compensability.

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

The medical evidence indicates that claimant's compensable injury combined with his preexisting right wrist deformity to cause or prolong his disability or need for treatment. Accordingly, claimant must prove that the compensable injury, rather than his preexisting deformity, is the major contributing cause of his need for right wrist surgery. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (December 30, 1992).

Here, Dr. Rockey, the attending physician, opined both that the compensable injury is the major contributing cause of claimant's need for surgery and that claimant would not have needed the surgery had he not sustained the compensable injury. Based on the unrebutted opinion of Dr. Rockey, we agree with the Referee that claimant has sustained his burden of proof.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 $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 statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1992 is affirmed. For services on review, claimant's attorney is awarded $1,500 payable by the insurer.

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In the Matter of the Compensation of
**DAVID L. JONES, Claimant**
WCB Case No. 91-06745
ORDER ON REVIEW
Malagon, Moore et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee McCullough's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that affirmed the award of 21 percent (31.5 degrees) scheduled permanent disability made for the left hand by the Order on Reconsideration. On review, the issue is rate and extent of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee affirmed the award of 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of claimant's left hand. We adopt the Referee's reasoning and conclusions regarding this issue with the following supplementation.

The Referee applied the standards in effect at the date of claim closure. We agree. The rules in effect on the date of the Notice of Closure or Determination Order control. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003 & former OAR 436-35-003. In this case, the applicable rules are those in effect on January 4, 1991, the date the Determination Order issued. WCD Admin. Order 6-1988 as amended by temporary rules adopted effective October 1, 1990 and November 20, 1990 (WCD Admin. Orders 15-1990 & 20-1990) are the rules which apply to the present case.

For the first time on review, claimant argues that the temporary rules adopted by WCD Admin. Orders 15-1990 & 20-1990 are invalid. Therefore, claimant argues, only the rules adopted by WCD Admin. Order 6-1988 apply to his case. Under those rules, claimant argues that he is entitled to a 5 percent award for a chronic condition limiting repetitive use of his left hand. Because claimant first raises this challenge to the validity of the temporary rules on review, we are not inclined to address it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, we recently rejected that argument in Eileen N. Ferguson, 44 Van Natta 1811 (1992). Thus, we find that the temporary rules noted above apply to this case. Martha E. Pardue, 44 Van Natta 1843 (1992).

In the alternative, claimant argues that his disability is not fully addressed by the standards, and he requests that we remand his case to the Director for adoption of an appropriate rule which would fully compensate him for his disability. Claimant also did not raise this issue at hearing. Under such circumstances, we again are not inclined to address it. See Stevenson v. Blue Cross of Oregon, supra. In any event, we recently held that we lack authority to remand to the Director for a finding that a claimant's disability is not addressed by the standards and for the adoption of temporary rules to accommodate such an impairment. Gary D. Gallino, 44 Van Natta 2506 (1992).

Also, essentially, the additional impairment award claimant seeks is addressed by the applicable standards regarding scheduled chronic condition impairment. Former OAR 436-35-010(8). However, because of explicit provisions in those standards, claimant does not qualify for this additional award.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the July 30, 1989 compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated September 4, 1991 is affirmed in part and reversed in part. That portion of the order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of $305 per degree is reversed. The award of an out-of-compensation fee to claimant's counsel payable from this increased compensation is also reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**DEBRA J. KENTTA, Claimant**
WCB Case No. 91-13897
ORDER ON REVIEW
Ronald Fontana, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of that portion of Referee Thye's order that upheld the self-insured employer's denial to the extent that it denied claimant's condition after a motor vehicle accident. The employer cross-requests review of those portions of the order that: (1) awarded a penalty and assessed attorney fee for an allegedly unreasonable denial of payment for a doctor's examination; and (2) awarded an assessed attorney fee for an allegedly procedurally improper denial of claimant's condition. On review, the issues are compensability and penalties 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 OPINION

Compensability

Claimant seeks to prove the compensability of her injuries under the "quasi-course of business" concept which, prior to the 1990 amendments to the Workers' Compensation Law, provided that injuries incurred while the worker was engaged in activities that, although outside the time and space limits of the employment, would not have been undertaken but for a compensable injury, were compensable. See, e.g., Fenton v. SAIF, 87 Or App 78, rev den 304 Or 311 (1987).

The court has recently held, however, that the 1990 amendments (specifically, ORS 656.005(7)(a)(A)) effectively overruled the rationale expressed in Fenton, supra. Hicks v. Spectra Physics, 117 Or App 293 (1992).

In Hicks, the claimant was injured in an automobile accident while returning from a treatment for her compensable injury. The employer denied her claim and the claimant requested a hearing, citing Fenton as authority for the compensability of her claim. The Board ultimately upheld the employer's denial, reasoning that Fenton had been overruled by the 1990 amendments.

The court agreed, citing legislative history for the proposition that subsequent to the 1990 amendments, "any injury or condition that is not directly related to the industrial accident is compensable only if the major contributing cause is the compensable injury. Hicks v. Spectra Physics, supra (emphasis in original).

Here, claimant left her work to see Dr. Rath for the effects of her compensable injury. She subsequently drove a short distance to a physical therapist's office and then to her son's day care center. While driving home with her son, claimant was struck from the rear by another vehicle. She sustained injuries as a result.

Assuming, without deciding, that claimant's claim would have been compensable under the pre-1990 law, as interpreted in Fenton, supra, it is now clear that the same claim is not compensable under Hicks, supra. The evidence is that the major contributing cause of claimant's most recent injuries is her automobile accident, rather than her original compensable injury. Accordingly, claimant's current claim is not compensable under ORS 656.005(7)(a)(A).

Penalties and Attorney Fees

On September 20, 1991, the employer denied "further responsibility" for claimant's "current condition" on the basis that claimant had "experienced a new and significant injury to your back in a [sic] automobile accident in February 1991." (Ex. 31-1). At hearing, the employer amended its denial to include the compensability of a July 9, 1991 examination by Dr. Rath and claimant's condition after the motor vehicle accident. (Tr. 1). With regard to Dr. Rath's examination, the employer specifically denied that claimant had seen Dr. Rath on that date and that, if she had, it was not for treatment related to her compensable injury. (Id. at 9-10).

On review, the employer does not challenge the Referee's conclusion that claimant proved that she was seen by Dr. Rath on July 9, 1991. Instead, it asserts that the Referee improperly awarded a penalty and assessed attorney fee because it had a legitimate doubt at the time that it issued its denial that claimant had seen Dr. Rath on July 9, 1991. Alternatively, the employer contends that, even if its denial was unreasonable, the Referee was prohibited in awarding both a penalty and assessed attorney fee.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The unreasonableness of a delay or refusal depends on whether the carrier had a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are considered in light of all the evidence available to the carrier at the time of denial. Id. Continuation of an otherwise reasonable denial, however, can become unreasonable if new medical evidence destroys any legitimate doubt about liability. Id. at 592.

The employer asserts that, after being informed by claimant's former treating physician in March 1991 that claimant was medically stationary on February 21, 1991, as of the date of its denial it had not received information that claimant was seen by Dr. Rath except for contradictory letters from him suggesting that he first saw claimant on July 10, 1991.

While there is no proof that the employer received the July 9, 1991 Form 827 signed by Dr. Rath, his chart notes, or his prescription for physical therapy as of the date it issued its denial, we conclude that the employer did receive a letter, dated September 11, 1991, from Dr. Rath stating that claimant "transferred her care for her on-the-job injury of 12-27-90 and [sic] to myself on 7-09-91. She,

unfortunately, subsequent to that visit * * * was injured in an auto accident * * *." (Ex. 28). We disagree with the employer's contention that Dr. Rath's letter is "confusing" and find that it informed the employer that claimant was examined by Dr. Rath on July 9, 1991. There is no contradictory evidence. Although Dr. Rath, in a letter dated September 18, 1991, indicated to North Pacific Insurance Company that he "first saw" claimant on July 10, 1991, it is unknown whether the insurer received the letter prior to issuing its September 20, 1991 denial.

Therefore, we find that as of the date the employer became advised of Dr. Rath's September 11, 1991 letter, the employer no longer had a legitimate doubt as to whether claimant saw Dr. Rath on July 9, 1991 and that its denial of payment for that visit, therefore, was unreasonable.

However, we agree with the employer that the Referee improperly assessed both a penalty under ORS 656.262(10) and an attorney fee under ORS 656.382(1) on the sole basis that the denial was unreasonable. See Nicolasa Martinez, 43 Van Natta 1638, 1640 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Furthermore, because there are amounts then due upon which to base a penalty, we decline to grant claimant's attorney's request that we affirm the award of an assessed attorney fee in lieu of the Referee's penalty award. See id. Therefore, we conclude that claimant is to receive only a penalty for the employer's unreasonable denial of Dr. Rath's bill for July 9, 1991, with her attorney to receive one-half "in lieu of an attorney fee." See ORS 656.262(10).

The employer also challenges the Referee's assessment of an attorney fee on the basis that its denial was procedurally invalid in that it denied future, as opposed to current, benefits for claimant's compensable injury.

Under ORS 656.245(1), a carrier may deny a currently claimed need for treatment before claim closure based on the assertion that the treatment is not related to the industrial injury. Evanite Fiber Corp. v. Striplin, 99 Or App 353, 356-57 (1989); Green Thumb, Inc. v. Basl, 106 Or App 98 (1991). However, if the carrier denies future responsibility for payment of benefits relating to a previously accepted claim and does not follow the statutory procedure for claim closure, the denial is procedurally improper. Id.

We conclude that the employer's denial, as amended at the hearing, was limited to claimant's current condition. Although the denial used the terms "future responsibility," it was expressly limited to claimant's "current condition" on the basis that such condition was the result of a motor vehicle accident. We find that the denial denied benefits for a "current need" without precluding future benefits. Therefore, we conclude that the denial is not procedurally improper and does not provide grounds for assessment of an attorney fee.

Finally, since penalties are not considered to be compensation, claimant is not entitled to an attorney fee for services on Board review devoted to successfully defending the Referee's penalty assessment. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

## ORDER

The Referee's order dated March 26, 1992 is affirmed in part and reversed in part. Those portions of the order awarding assessed attorney fees are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**GLOW I. MEISSNER, Claimant**
WCB Case No. 91-13149
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of that portion of Referee McWilliam's order that upheld the SAIF Corporation's partial denial of her current low back condition. Claimant also objects to the Referee's ruling that a June 20, 1991 chart note was not admissible. On review, the issues are evidence and compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

At the beginning of the hearing, SAIF objected to the admission of a June 20, 1991 chart note authored by claimant's treating physician, Dr. Sharrer. (Exhibit 8D). SAIF asserted that, although claimant had been in possession of the document since July 22, 1991, SAIF was not provided with a copy of it until December 19, 1991, four days before the hearing. At hearing, the Referee found that SAIF had been prejudiced by the late disclosure and ruled that the exhibit was not admissible. (Tr. 6).

Claimant objects to this ruling. She alleges that, prior to filing her claim against SAIF, she had filed a claim against another carrier and disclosed the disputed document to that carrier. The carrier disclaimed responsibility, naming SAIF as potentially responsible. Claimant asserts that the document, therefore, was available to SAIF either through the other carrier or as a result of SAIF's own duty to investigate the claim. Furthermore, claimant contends that SAIF was not prejudiced by the late disclosure.

Although the Referee did orally rule at hearing that the chart note was not admissible, she referred to the document in her order, quoting from it in the findings of fact and discussing it in her conclusion that claimant had not proved compensability. Furthermore, the document was included in the record certified by the Referee under ORS 656.295(3). Under these circumstances, we find that the Referee, in effect, reversed her ruling that the chart note was not admissible and instead considered it in her order.

Moreover, we further conclude that the Referee did not abuse her discretion in deciding that the exhibit was admissible. We note in this regard that referees have great discretion to allow or deny admission of evidence at hearing. Shirlene E. Volcay, 42 Van Natta 2773 (1990). Under the facts here, we conclude that the Referee's ruling was appropriate under the "substantial justice" standard set forth in ORS 656.283(7). Therefore, we consider Exhibit 8D on review.

### Compensability

Claimant next objects to the Referee's application of ORS 656.005(7)(a)(A) to analyze compensability. Claimant asserts that her current condition is the same condition that was accepted by SAIF in 1978 and, therefore, her current condition was directly caused by the 1978 industrial accident. Consequently, claimant contends that her condition is not a consequential condition under ORS 656.005(7)(a)(A) and that she need only prove that the industrial accident was a material contributing cause of her current condition. We conclude that, whether the major contributing cause standard or the material contributing cause standard is applied, claimant failed to prove compensability.

In 1978, while working for SAIF's insured, claimant compensably injured her low back. After claimant underwent a left L4-5 laminectomy and discectomy in 1981, the claim was closed by a

January 15, 1982 Determination Order. Later that year, claimant suffered another injury in Colorado when she fell down a stairway. That claim was denied by SAIF.

Claimant sought treatment for her low back from Dr. Sharrer in June 1991. With regard to claimant's current condition, the record contains only Dr. Sharrer's chart note stating "[s]tatus post L4-5 laminectomy with subsequent degenerative disc disease and some sciatica." (Ex. 8D). Claimant relies on this statement in asserting that her current condition is the same as that accepted by SAIF in 1978 and, therefore, her need for treatment is compensable.

We do not find Dr. Sharrer's chart note sufficient to carry claimant's burden of persuasion. In this regard, we agree with the Referee that medical causation in this case is a complex question which requires reliance on expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967). Dr. Sharrer's chart note does not indicate any knowledge of claimant's medical history, including her 1982 off-work fall and her subsequent work activities. In light of the apparent lack of such knowledge, as well as the conclusory nature of the chart note, which contains solely a diagnosis, we conclude that whether analyzed under ORS 656.005(7)(a) or 656.005(7)(a)(A), claimant failed to prove compensability. Therefore, her claim fails.

ORDER

The Referee's order dated January 23, 1992 is affirmed.

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In the Matter of the Compensation of
**MILTON A. NELMS, Claimant**
WCB Case No. 92-01384
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Claimant has requested reconsideration of our December 22, 1992 Order on Review. Specifically, claimant contends we did not address his cross-request for review concerning the offset issue. Although claimant did not file a brief, he did formally cross-request review of that portion of the Referee's order that authorized the insurer to offset permanent disability benefits paid pursuant to a Determination Order. Inasmuch as the issue was properly raised and our previous order did not address it, we proceed to address it at this time.

The Referee authorized the insurer to "offset" unscheduled permanent disability, paid pursuant to the Determination Order, against claimant's current award of unscheduled permanent disability. We agree.

The Determination Order granted claimant 11 percent unscheduled permanent disability. That amount was paid to claimant by the insurer. The Order on Reconsideration reduced claimant's award to 4 percent, thereby creating an overpayment of unscheduled permanent disability equal to 7 percent. In his order, the Referee increased claimant's award of unscheduled permanent disability to 13 percent. The Referee's award was not appealed.

Thus, by virtue of the Referee's increased award of unscheduled permanent disability, the overpayment created by the Order on Reconsideration no longer existed. Rather, claimant is now substantively entitled to a total award of 13 percent unscheduled disability. However, inasmuch as the insurer has already paid 11 percent of that award pursuant to the Determination Order, it is not required to pay the full 13 percent ordered by the Referee. It is only required to pay the 2 percent that has not been previously paid. In this circumstance, the 11 percent paid pursuant to the Determination Order is better characterized as a "pre-payment" rather than an overpayment.

Although the Referee characterized the issue as an offset for an overpayment, he authorized the offset only against claimant's current award. Therefore, regardless of the characterization, the Referee

correctly allowed the insurer to credit amounts paid pursuant to the Determination Order against amounts awarded by his order. Under these circumstances, we agree with and affirm the Referee as to this issue.

Accordingly, our December 22, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ANGELO L. RADICH, Claimant**
WCB Case No. 92-01156
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The insurer requests review of Referee Myzak's order that set aside its denial of claimant's claim for a rib and chest injury. In his brief, claimant argues that the insurer's denial was unreasonable. On review, the issues are compensability, penalties and attorney fees. We reverse.

## FINDINGS OF FACT

Claimant works for the employer as a carpet salesman. Although his work station is located in the basement of the employer's store, claimant often climbs and descends nine stair steps located between the main floor showroom and the basement.

On September 18, 1991, claimant told a co-worker that he had injured himself falling on the stairs at work. He ultimately alleged that he had injured himself two days before, although he did not advise anyone at work of the incident on the day it allegedly occurred.

On September 20, 1991, claimant sought treatment for a rib contusion and the injury was later diagnosed as a fractured rib. On September 27, 1991, claimant filed a claim for this injury.

The employer utilizes carpet samples on which labels are ironed by a worker stationed near the foot of the stairway upon which claimant alleges to have been injured. Claimant alleged that he noticed one of these labels on the stairs after he fell. No other worker has ever seen a label outside of the partitioned area where labels are ironed on to samples, however.

Claimant began playing football regularly in September 1991. He participated in a practice on September 17, 1991, the day after the alleged work injury.

## CONCLUSIONS OF LAW AND OPINION

Claimant bears the burden of proving the compensability of the claimed injury. ORS 656.266. To carry that burden, claimant must establish, by medical evidence supported by objective findings, that he suffered an accidental injury which arose out of and in the course of his employment and that the injury was a material contributing cause of his disability or need for medical services. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

In this case, the pivotal question is whether or not claimant injured himself in the course of his employment. Because the claimed injury was unwitnessed, claimant's credibility is of particular importance.

The Referee found that the injury happened as claimant described it. In doing so, she found all witnesses, except Mr. Leamy and Ms. Grepo, claimant's coworkers, to be credible.

Although we generally defer to a Referee's demeanor-based credibility findings, we do not do so where inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. See Erck v. Brown Oldsmobile, 311 Or App 519, 528 (1991) ("Although the Board should seriously consider the testimony the referee believes to be reliable, the 'substantial evidence' standard does. not require the Board to adopt the referee's findings or to 'explain away' disparities between the Board's and the referee's determinations"); see also Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Because this is such a case, we do not defer to the Referee's credibility findings. See Davies v. Hamel Lumber Co., 67 Or App 35 (1984); see also William K. Porter, 44 Van Natta 937 (1992).

Claimant's testimony regarding the alleged September 16, 1991 work injury is inconsistent with and unsupported by his contemporaneous behavior, as well as the testimony of other witnesses. Although it is undisputed that claimant suffered a broken rib sometime before September 20, 1991, he alleges that his injury occurred on September 16, 1991. Yet, he told no one at work that he was hurt until September 18, 1991. Further, he did not seek medical treatment until September 20, 1991. Considering the severity of the injury, claimant's delay in reporting it prompts us to question when his injury, in fact, occurred.

In addition, claimant admits that his fall was noisy, and that there were coworkers near the injury site when it allegedly happened. (Tr. 39). Some of these coworkers had heard others fall on these same stairs in the past. None, however, heard claimant, or anyone else, fall on the date in question. Due to the undisputed severity of the injury and the presence of persons who likely would have heard a fall, had it occurred, that they did not on September 16, 1991 causes us to question where claimant was injured.

Claimant surmised that he fell on the stairway because he slipped on a carpet label. (See Tr. 16). He testified that labels were applied to carpet samples in "no set area," that labels could be found in "a wide variety of places," and that it was not unusual to see labels "lying around frequently." (Tr. 17). Claimant's description of how and where sample labelling occurred is directly contradicted by his co-workers, however. No coworker has ever seen a carpet label outside of the partitioned area where labels were affixed to the samples. These discrepancies cause us to question how claimant was injured, as well.

Claimant testified that he was embarrassed after his fall and, though he felt pain, it was not debilitating or severe. (Tr. 18-19). On the other hand, claimant previously reported that he felt "acute pain" immediately following the injury and that his symptoms "came suddenly." (Exs. A, 5A).

None of claimant's coworker's noted him to be in pain at work on the day of the alleged injury. Further, claimant's family and friends apparently were unaware of his symptoms until after his football practice on September 17, 1991, the day after the claimed work injury.

Although claimant did not deny that he participated in football practice on September 17, 1991, he testified that practice sessions were not regularly scheduled. This statement was directly contradicted by Mr. Boothroyd, claimant's friend. (Tr. 78). In addition, although claimant maintained that he injured himself at work rather than at football practice, two co-workers testified that they overheard him tell someone that he had injured his rib during practice. (Tr. 93, 128-29). Finally, although claimant contended that he fell at work after lunch (around two o'clock in the afternoon), Boothroyd testified that he picked claimant up at his home to go to lunch at one or two o'clock in the afternoon on the day claimant was injured. (Tr. 73-80). Boothroyd further recalled claimant explaining that he was at home because he was injured. (Tr. 75). On the other hand, claimant has never asserted that he left work due to his injury on September 16, 1991.

Considering the aforementioned inconsistencies, contradictions and discrepancies, we are not persuaded that claimant was a truthful witness. We, therefore, do not rely on his testimony. Under these circumstances, we conclude that claimant has not carried his burden of proving that his injury occurred in the course of his employment.

## ORDER

The Referee's order dated May 1, 1992 is reversed. The insurer's denial is reinstated and upheld.

In the Matter of the Compensation of
**FELIPE A. ROCHA, Claimant**
WCB Case No. 91-15621
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Bethlahmy's order that: (1) directed SAIF to pay temporary disability granted by a Notice of Closure; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, SAIF contends that it was entitled to stay the payment of the temporary disability because its appeal of a prior Referee's compensability decision was pending review. We agree and reverse.

FINDINGS OF FACT

A May 1991 Referee's order found claimant's epigastric hernia condition to be compensable. Consequently, the Referee set aside SAIF's denial of claimant's occupational disease claim for the condition and remanded the claim for "acceptance, processing, and payment of compensation to which claimant is entitled pursuant to the Oregon Workers' Compensation law." SAIF timely requested Board review of the Referee's order.

On September 24, 1991, SAIF issued a Notice of Closure. The notice provided that claimant was entitled to temporary total disability, less time worked, from July 16, 1990 through September 5, 1990.

On October 24, 1991, SAIF notified the Compliance Section that the aforementioned temporary disability award had not been paid since its appeal of the Referee's order was pending review. Thereafter, claimant requested a hearing, seeking payment of the award and a penalty.

CONCLUSIONS OF LAW

The Referee ruled that SAIF's appeal of the earlier referee's compensability order did not stay its obligation to pay the temporary disability granted by the Notice of Closure. In reaching this conclusion, the Referee relied on Carol D. Goss, 43 Van Natta 2647 (1991), which held that the "stay of compensation" provision in ORS 656.313 applies only to a carrier's appeal from the order which awards the compensation in dispute. Since claimant's temporary disability award was granted by the Notice of Closure and because SAIF's appeal pertained to the earlier referee's compensability decision, the Referee held that SAIF was not entitled to stay the payment of the temporary disability. Determining that SAIF's conduct was unreasonable, the Referee also assessed a penalty.

Amended ORS 656.313(1) provides that the filing by a carrier of a request for hearing on a reconsideration order or a request for Board review stays payment of the compensation appealed, except for two exceptions not presently applicable. Relying on that statute, SAIF contends that it is entitled to stay any and all compensation generated as a result of the appealed earlier Referee's order (except temporary disability benefits that accrued from the date of the appealed Referee's order as provided by ORS 656.313(1)(a)(A)). In essence, SAIF seeks the partial disavowal of our holding in Goss.

In Goss, the claimant's claim was determined compensable by a Referee, who ordered the employer to accept and process claimant's claim according to law. The employer appealed the Referee's order, but continued to process the claimant's claim to closure via a Determination Order (DO), which awarded both temporary and permanent disability compensation. Relying on ORS 656.313(1), the employer did not pay the compensation awarded by the DO pending the employer's appeal of the Referee's order. The employer did not, however, request reconsideration of the DO. The claimant requested an enforcement hearing and a new Referee ordered payment of the compensation awarded in the DO.

We affirmed the Referee's order in Goss, holding that ORS 656.313(1) stays only the compensation appealed, i.e., only the compensation ordered payable in the order actually appealed from. In Goss, the employer appealed the Referee's order regarding compensability, but did not request

reconsideration of the later-issued DO. Therefore, we concluded that in order to stay payment of compensation, the employer would have had to request reconsideration of the DO itself.

Here, SAIF argues that: (1) Goss is distinguishable since closure was by notice rather than a DO; or (2) Goss should be disavowed. With regard to its first argument, SAIF asserts that it would not request reconsideration from its own Notice of Closure. With regard to its second argument, SAIF contends that the effect of Goss is to require carriers to pay compensation that is specifically allowed stayed by ORS 656.313.

We need not address SAIF's first argument because, after further reflection, we consider the Goss rationale (insofar as it pertains to "pre-litigation order" temporary disability) to be inconsistent with ORS 656.313. Our conclusion is based on the following reasoning.

ORS 656.313 clearly foresees the processing of a claim and the payment of temporary disability benefits resulting from a Referee or Board decision finding a claim compensable. Section (1)(a)(A) provides for the stay of compensation appealed except for the payment of 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. The emphasized portion of the statute confirms that the statute is applicable to a litigation order finding a claim compensable and directing the carrier to process the claim in accordance with law; i.e., pay compensation to which the claimant is statutorily required.

The Goss holding suggests that, once a closure notice/order issues, a carrier will be required to pay "pre-litigation order" temporary disability pending its appeal of a Referee/Board compensability decision. Such a conclusion would be in conflict with the stay of compensation provisions in ORS 656.313. The following scenario demonstrates this incongruity.

A Referee overturns a compensability denial and orders the carrier to process the claim. The carrier requests Board review and initially does not pay temporary disability, relying on ORS 656.313. It does, however, continue processing the claim through closure by DO. The DO awards "pre-litigation order" temporary disability. The carrier requests reconsideration of the DO. However, OAR 436-60-150(4)(e) requires the commencement of temporary disability awarded by a DO within 14 days of its issuance. This rule further provides that a request for reconsideration does not stay the payment of such benefits. Id.

By its terms, ORS 656.313 does not stay compensation pending the reconsideration process; it only stays compensation pending a "request for hearing on a reconsideration order." Therefore, under the Goss holding, the carrier would be required to pay "pre-litigation order" temporary disability beginning 14 days after the DO and continuing through the reconsideration process. Such a conclusion is contrary to ORS 656.313, which expressly allows a stay for the payment of "pre-litigation order" temporary disability pending a carrier's request for Board review or court appeal.

The Director's rules are consistent with this analysis of ORS 656.313. Concerning the timely payment of temporary disability, Section (4)(e) of OAR 436-60-150 provides that "If an order has been appealed by the insurer pursuant to ORS 656.313, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order." Section (4)(f) further states that temporary disability becomes due within 14 days from "The date any litigation authorizing retroactive temporary disability becomes final."

Relying on SAIF v. Roles, 111 Or App 597 (1992), the dissent reasons that, in the absence of a timely appeal from a subsequent litigation order, a carrier would be required to pay an "erroneous" award granted by that subsequent order "to preserve its right to stay" compensation which it was entitled to do through its appeal of the earlier litigation order. Inasmuch as the express provisions of ORS 656.313 distinguish this case from Roles, we disagree with the dissent's analysis.

In Roles, the court concluded that, although an earlier Referee may have been in error in exercising his authority to award temporary disability under apparently untimely appealed Determination Orders, such an erroneous exercise of authority did not deprive the Referee of subject matter jurisdiction. The earlier Referee's apparent error in Roles was in misapplying former ORS

656.319(4), which pertained to timely requests for hearings regarding Determination Orders. Inasmuch as the earlier Referee apparently erroneously concluded that the appeals from the Determination Orders were timely, the Referee proceeded to exercise his authority to award additional temporary disability under those orders.

In the dissent's scenario, as in Roles, a Referee or the Department would have authority to award temporary disability arising from the closure of a claim. Nevertheless, rather than a general authority statutory provision as was present in Roles, the dissent's example describes a situation where the Department or Referee would be purporting to award compensation in direct contravention of a specific statutory directive. Specifically, in the dissent's example, the subsequent litigation order would be attempting to essentially countermand an express statutory provision (ORS 656.313(1)(a)). Moreover, that statute was continuing to authorize the stay of the very compensation that the subsequent order was purporting to award. In light of this explicit statutory mandate regarding the stay of certain benefits pending appeal, we cannot agree with the dissent's extension of the Roles' holding.

Likewise, we disagree with the dissent's conclusion that the Department merely "discuss[es] the inclusive dates" for a claimant's temporary disability, rather than awards such benefits. A review of the Department's standard form reveals that it entitles its action as a "Determination Order." Consistent with that title, the Department "orders" entitlement to temporary total and/or temporary partial disability compensation, less time worked, for certain specified periods. This language is in accordance with OAR 436-60-150(2)(e), which requires the timely payment of temporary disability within 14 days from "[t]he date of any department order which orders payment of temporary disability." (Emphasis supplied). Thus, barring the existence of an already pending appeal permitting the stay of "pre-litigation order" temporary disability, such retroactive benefits awarded by a subsequent litigation order would be due and payable within 14 days of that order.

The dissent reasons that in "those limited circumstances where the department actually but erroneously orders the payment of temporary disability stayed under ORS 656.313(1)(a), the parties must comply with that order or face a potential enforcement proceeding and an award of penalties." We again disagree.

To begin, as discussed above, the stay of compensation occasioned by a carrier's appeal of the "compensability" decision would extend to subsequently ordered compensation. As previously explained, to do otherwise would contravene the express language of the statute.

Secondly, the Department has not "erroneously" ordered the "pre-litigation order" temporary disability. Instead, the Department is merely performing its statutory duty in evaluating processing decisions rendered by a carrier in submitting the claim for closure. After conducting this evaluation, the Department is required to issue an order regarding, among other matters, a claimant's entitlement to temporary or permanent disability benefits. In the event that this closure order is not appealed and becomes final, the parties would be precluded from contesting the amounts awarded by that order. See Drews v. EBI Companies, 310 Or 134 (1990); Brown v. Nelson International, 117 Or App 24 (1992). Thus, if the Department neglects to "erroneously" order the payment of "pre-litigation order" temporary disability and claimant fails to timely appeal that decision, claimant would be precluded from subsequently seeking entitlement to benefits arising from that claim closure.

In essence, when a "compensability" appeal remains pending and "pre-litigation order" temporary disability is being stayed, the subsequent claim closure order that awards "pre-litigation order" temporary disability is granting the benefits on a conditional basis. That is, if the claim is ultimately found compensable (and the closure order is not on appeal to the Hearings Division, Board or court), the stay will be lifted and the previously withheld benefits (including accrued interest) will become due and payable within 14 days after the date the appealed litigation order becomes final. This reasoning is also consistent with OAR 436-60-150(4)(f). On the other hand, if the claim is ultimately found not compensable, the stayed benefits will never become due.

When the claim closure order is viewed in this "conditional" manner, it would be unnecessary for either party to seek further review of the closure order to somehow "resuscitate" the stay of compensation as the dissent suggests. Thus, unless it was otherwise in disagreement with the order, a carrier would not be required to appeal the closure to "preserve" the previously acquired stay of

compensation. Not only is this interpretation consistent with the "stay" requirements of ORS 656.313(1)(a), but it satisfies an objective of the Workers' Compensation Law to reduce litigation and eliminate the adversary nature of the compensation proceedings to the greatest extent practicable. See ORS 656.012(2)(b).

Based on the aforementioned reasoning, we conclude that, in accordance with ORS 656.313(1), a carrier is entitled to stay the payment of "pre-litigation order" temporary disability pending its appeal of a Referee/Board compensability decision. To the extent that this holding is inconsistent with the rationale articulated in Goss, the Goss holding is disavowed.

We apply this reasoning to the present case. The Notice of Closure awarded temporary disability between July 16, 1990 and September 5, 1990. This time period preceded the May 1991 Referee's order that found the claim compensable and directed SAIF to process the claim according to law. Inasmuch as SAIF requested Board review of that Referee's order and because the temporary disability award was not for a period accruing from the date of that Referee's order, SAIF was entitled to stay the payment of that award pending its appeal.

Accordingly, we reverse the Referee's order directing SAIF to pay the temporary disability award. Since we have found that SAIF was statutorily entitled to stay payment of the temporary disability award, it naturally follows that its conduct was not unreasonable. Consequently, we also reverse the Referee's penalty assessment.

ORDER

The Referee's order dated March 9, 1991 is reversed.

**Board members Hooton and Gunn concurring and dissenting.**

We agree with the result reached by the majority. However, we disagree with the rationale followed to reach that result, and foresee potentially dangerous consequences as a result of that reasoning. We conclude that ORS 656.313 does stay the payment of "pre-litigation order" temporary disability compensation and conclude that a Notice of Closure does not affect the stay allowed under ORS 656.313. We do not accept, however, that ORS 656.313 frees any party from the duty to comply with a subsequent order. Therefore, we concur in part and dissent in part.

ORS 656.313(1) provides in pertinent part as follows.

> "(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,...
>
> * * *.
>
> "(b) If ultimately found payable under a final order, benefits withheld under this subsection shall accrue interest at the rate provided in ORS 82.010 ..."

It is not possible to conclude from the language of the statute that compensation is stayed until a final order issues in the case in which the stay was granted. A subsequent order finding compensation immediately payable, if allowed to become final, meets the requirements of ORS 656.313(1)(b). Under such circumstances, the compensation stayed pending appeal would be payable under the subsequently issued final order, even if the case in which the stay was originally granted had not yet become final. This result follows from the reasoning that is the basis of the court's decision in SAIF v. Roles, 111 Or App 597 (1992).

The question, then, as it relates to the present dispute is, what is a final order? Certainly no one would contend that an Opinion and Order issued by a referee and from which no appeal was taken is not a final order. Consequently, if a hearings referee erroneously found that temporary disability compensation properly stayed pursuant to ORS 656.313(1)(a) had not been stayed and was immediately payable, the employer is not free to ignore the specific order of that referee, even though erroneous, but must appeal the order to preserve its right to a stay. If the order of that referee is allowed to become final the employer, or its insurer, must immediately pay the compensation ordered, regardless of the fact that this same compensation is stayed by appeal of a prior order under ORS 656.313(1)(a).

In like manner, a Determination Order which goes unappealed is a final order of the Department. Consequently, where a Determination Order requires the payment of temporary disability compensation stayed pursuant to ORS 656.313(1)(a) the employer/insurer must appeal the Determination Order or comply with it.

Unlike an Opinion and Order or a Determination Order, however, each of which is issued by a tribunal with the jurisdiction to address and resolve disputed facts or entitlement, a Notice of Closure is not an order, but is in fact, as its name implies, a notice provided to claimant by the insurer of benefits to which the insurer agrees claimant is entitled. Consequently, the majority assertion that the NOC in this claim "awarded" anything is technically inaccurate. In operation a Notice of Closure is more akin to an evidentiary stipulation than an Order.

Because the stay of compensation in the present claim was not affected by a subsequent order which had become final by operation of law, the insurer remained entitled to continue to rely upon the stay granted by its appeal of the litigation order finding the claim compensable.

The situation in Carol D. Goss, 43 Van Natta 2637 (1991) is very different from the situation presented in the present claim. In Goss a litigation order finding the claim compensable was appealed. The insurer was entitled to a stay of compensation by virtue of that appeal. While the appeal was pending a Determination Order issued requiring the payment of some compensation. The employer allowed that Order to become final. The stay of compensation, which was applicable only to the order appealed, did not remove the obligation of the insurer to pay the unappealed and final Determination Order.

The majority reasons that Goss is inconsistent with ORS 656.313. We disagree. The majority asserts that since ORS 656.313 does not stay the payment of compensation pending the reconsideration process the insurer "would be required to pay 'pre-litigation order' temporary disability beginning 14 days after the [issuance of a Determination Order]. The majority misunderstands the effect of a DO.

In closing a claim the Department is entitled to review the compensation due on the claim and to establish that period to which claimant is entitled to temporary disability compensation. The Department also determines the date upon which claimant became medically stationary and establishes the claimant's extent of permanent partial disability if any. The Determination Order also includes specific order language which directs the insurer to pay some or all of the benefits discussed in the Order. However, the amount of any award actually ordered paid is usually limited only to the permanent partial disability award. Despite the fact that the Department has jurisdiction to order the payment of temporary disability, it usually does not do so. What the Department does do, on temporary disability questions, is merely to discuss the inclusive dates during which the claimant was entitled to receive temporary disability compensation and provide that the insurer may recover any temporary disability actually paid for dates not included within that period of entitlement. Therefore, while the Determination Order is an order with which the parties must comply, or which the employer must appeal to preserve a stay, a Determination Order will affect a stay of temporary disability compensation only in those rare cases where the Department actually orders the payment of a period of temporary disability not previously paid by the insurer. In light of ORS 656.313(1)(b), in those limited circumstances where the department actually but erroneously orders the payment of temporary disability compensation stayed under ORS 656.313(1)(a), the parties must comply with that order or face a potential enforcement proceeding and an award of penalties.

In Goss the statement of facts does not provide sufficient information to determine whether the Board previously erred in finding that a temporary disability entitlement period established by the Department was a portion of the award made payable by the order. If that case included temporary disability compensation, and the order portion of the Determination Order did not include a specific directive to pay temporary disability compensation, then the DO did not award compensation at variance with the stay provision of ORS 656.313. However, the holding in Goss remains an accurate and appropriate statement of the law. In that case we simply stated that "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." 43 Van Natta @ 2639. (Emphasis added). That statement of the law is correct and complete. It is error, now to disavow it.

In the Matter of the Compensation of
**JACK W. SANFORD, Claimant**
WCB Case Nos. 90-05108 & 90-05109
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Reliance Insurance Company (Reliance) requests review of Arbitrator Hazelett's order that: (1) set aside its denial of claimant's "new" occupational disease claim for a current low back condition; and (2) upheld Aetna Casualty Company's (Aetna) denial of claimant's aggravation claim for the same condition. On review, the issues are scope of review and responsibility.

We affirm and adopt the order of the Arbitrator, with the following supplementation.

Applicable law

The initial hearing in this responsibility matter convened on June 25, 1990, whereupon it was continued until July 26, 1990. Following the hearing, the Arbitrator issued an order on July 30, 1990. Aetna timely requested Board review. The Board issued an Order on Review which remanded the case to the Arbitrator for admission of post-hearing medical evidence. See Jack W. Sanford, 43 Van Natta 1395 (1991). The hearing on remand was held on February 27, 1992 and the order presently appealed issued on April 14, 1992.

Because the hearing in this matter convened prior to July 1, 1990, the Arbitrator properly applied responsibility law in effect prior to the 1990 amendments to Workers' Compensation law. That is the law we apply as well.

Scope of review

All parties contend that our scope of review of the Arbitrator's order is de novo under ORS 656.307(2). We do not agree.

ORS 656.307(a) provides, in relevant part:

> "* * * Review of the determination of the arbitrator by the board and by the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body. However, if the claimant can establish on the arbitration record, that the determination resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board and the Court of Appeals shall be as provided for matters concerning a claim." ORS 656.307(2).

ORS 656.704(3) defines matters concerning a claim as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

We have held that evidence that a worker's temporary disability rate and/or aggravation date varies depending on which insurer is responsible does not, of itself, mean that a matter concerning a claim is "directly in issue." See Richard H. Long, 43 Van Natta 1309 (1991), aff'd mem Long v. Continental Can Co., 112 Or App 329 (1992); John L. Riggs, 42 Van Natta 2816 (1990). On the other hand, where a different assignment of responsibility will affect a matter concerning a claim and claimant argues on review that the Referee erred, such a matter is directly in issue and our de novo review authority is triggered under the statute. See Jon E. Robinson, 42 Van Natta 512 (1990).

In this case, claimant has neither requested nor cross-requested review of the Arbitrator's responsibility determination and, in fact, seeks its affirmance. Because claimant challenges no aspect of the Arbitrator's decision affecting claimant's right to receive compensation or the amount thereof, no matter concerning a claim is directly in issue before us. Therefore, we review the Arbitrator's

responsibility determination for questions of law only. ORS 656.307(2); see Richard H. Long, supra; John L. Riggs, supra.

Responsibility

The Referee found that claimant's work activities during Reliance's coverage independently contributed to a pathological worsening of claimant's low back condition and consequently, responsibility for that condition shifted from Aetna (the last insurer with an accepted low back claim), to Reliance. After conducting our review, we hold that it was not an error of law for the Arbitrator to conclude that Reliance is responsible for claimant's low back condition. See Multnomah County School District v. Tigner, 113 Or App 405 (1992) citing UAC/KPTV Oregon TV, Inc. v. Hacke, 101 Or App 598, 602 n. 2 rev den 310 Or 393 (1990); Hensel Phelps v. Mirich, 81 Or App 290 (1986). Accordingly, we affirm the Arbitrator's responsibility determination.

ORDER

The Arbitrator's order dated April 14, 1992 is affirmed.

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In the Matter of the Compensation of
**SYLVIA L. VERHELST, Claimant**
WCB Case No. 91-12495
ORDER ON REVIEW
Zbinden & Curtis, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of her claim for low back surgery. 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 found that claimant had not proven that her compensable injury caused the L4-5 disc herniation which necessitated surgery or that the injury had worsened her preexisting degenerative disc condition resulting in the L4-5 herniation. We agree with the Referee that claimant has failed to establish compensability of her L4-5 disc condition and resulting surgery.

The relationship of the L4-5 disc herniation, discovered in 1991, to the 1990 accepted back strain presents a complex medical question of causation which must be resolved by expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967). Three physicians address the causation of the disc herniation which resulted in claimant's need for lumbar surgery.

Dr. Gray treated claimant at the time of the industrial injury in January 1990. X-rays taken at that time showed a normal lumbar spine except for a moderately severe degenerative disc change at L5-S1. Claimant did not receive treatment for her back condition between February 2, 1990 and January 16, 1991 when she returned to Dr. Gray with a two or three month history of back pain. Dr. Gray took an x-ray of the lumbosacral spine which again showed abnormal narrowing of the L5-S1 interspace which was unchanged from the previous x-ray of January 26, 1990. Because of claimant's radicular symptoms, Dr. Gray suspected a protruded lumbar disc and scheduled a CT scan. A lumbosacral CT performed on January 29, 1991 and a February 4, 1991 lumbar myelogram revealed a disc herniation at L4-5. Dr. Gray felt that there were no other factors contributing to the L4-5 herniation other than claimant's January 1990 compensable injury. Dr. Gray opined:

"This patient's symptoms were more or less identical to when she was initially seen in 1990 and she was relatively free of this for a period of time, but I feel we have to go back to the original injury and feel there is no doubt in my mind but that this was the major contributing cause to her back and legs, and need for surgery on her back."

We find Dr. Gray's opinion to be conclusory and lacking in explanation and analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Gray does not explain the relationship between the preexisting degenerative changes in claimant's spine and the herniation at L4-5. Furthermore, Dr. Gray does not adequately explain how the L4-5 herniation was related to the January 1990 injury when claimant's symptoms abated enough that she continued to perform her regular work and did not require medical treatment for almost a year. For these reasons, we find Dr. Gray's opinion to be unpersuasive.

Dr. Gray referred claimant to Dr. Franks, a neurosurgeon, for treatment of the disc herniation. Dr. Franks felt that the disc had been damaged by the January 1990 injury and the herniation had subsequently occurred due to a gradual progressive post traumatic degenerative change in the disc. Dr. Franks based his opinion on the fact that claimant had suffered no intervening injuries to her back and on the fact that claimant's symptoms as a result of the disc herniation were identical to the symptoms she suffered as a result of the January 1990 injury.

We are not persuaded by Dr. Franks' opinion. He does not address the fact that claimant had preexisting degenerative disc disease at L5-S1 which was already present at the time of the original injury. Moreover, he does not explain whether there was a relationship between the L4-5 disc herniation and the preexisting degenerative condition. Finally, the initial history he took from claimant indicated that claimant had been having a "different" pain radiating down her left leg for about a month. This history contradicts Dr. Franks' later assertion that claimant's symptoms due to the disc herniation were identical to those present at the time of the original injury. For these reasons, we do not find Dr. Franks' opinion persuasive.

Dr. Thompson, an orthopedic surgeon, did a records review for the insurer. He felt that the disc herniation was the result of the natural degenerative process in the lumbar spine. Thompson explained that the degenerative process can cause disc herniations without any significant injury. Dr. Thompson did not believe there was a pathophysiologic connection between the incident in January 1990 and the herniated disc discovered in 1991. He based his opinion on the fact that claimant worked for eight or nine months without any difficulty following the original strain and there was a period of time after that before claimant's leg pain, which was related to the herniation, began.

We find Dr. Thompson's opinion to be well-reasoned and based on complete information. Therefore, we find his opinion that the disc herniation is related to the preexisting degenerative disc disease rather than the compensable injury to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

The Referee found that Dr. Thompson's opinion was internally inconsistent because Thompson stated on one hand that claimant's disc herniation was caused by a degenerative process while on the other hand, Thompson opined that the herniation progressed to a level requiring surgery at too remote a time from the injury for the herniation to be related to that injury. We do not agree that Thompson's opinion is internally inconsistent. We read the opinion to mean that claimant's disc herniation resulted from the degenerative process rather than from trauma due to the injury. Consequently, the lapse in time between the need for surgery and the injury supports Thompson's theory that the herniation was due to the degenerative condition rather than the compensable injury.

Accordingly, based on this reasoning, we agree with the Referee that claimant has not established compensability of the L4-5 disc herniation and resultant need for surgery.

## ORDER

The Referee's order dated March 31, 1992 is affirmed.

In the Matter of the Compensation of
**JOHN W. WALTERS, Claimant**
WCB Case No. 91-02919
ORDER ON REVIEW
Becker, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Crumme's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a fungal condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On September 4, 1990, claimant began his job as branch manager of the employer's Tigard lawn and shrub care service. Claimant was in training during his first two weeks on the job. He engaged in only limited field duties during training. After training, he commenced his regular duties.

As part of his regular duties, claimant spent about 10 hours a week making service calls to customers' premises. On these service calls, he would often be in close contact with vegetation, either to inspect for fungal growth or to spray chemicals. Claimant also had some contact with vegetation at the employer's warehouse.

Claimant was frequently scratched by thorny plants when he made service calls for the employer.

Prior to beginning work on September 4, 1990, claimant had sinus problems for at least several months. (Ex. 20).

In early to mid-September 1990, claimant first began to notice swelling in his hands. By October 4, 1990, he had developed multiple symptoms of pain and swelling in his different extremities, for which he sought examination by nurse practitioner Madelene Anderson. (Ex. 4). After October 4, 1990, the pain and swelling in claimant's extremities continued and he developed additional problems, including chronic recurrent sinusitis and large, ulcerated sores over much of his skin. (Exs. 20 and 36).

On December 21, 1990, claimant's supervisor, Mitchell Smith, fired him for job performance reasons. During their conversation about claimant's termination, claimant told Mr. Smith that he believed his condition was caused by his work activities, but that claimant would not file any claim unless and until he was able to establish a causal relationship between his work and his physical condition.

Other than claimant's conversation with his supervisor on December 21, 1990, the employer did not receive notice or knowledge that claimant or his physicians asserted that his symptoms were due to an occupational disease until January 7, 1991. (Exs. 40, 42, 52, and 53).

On January 18, 1991, the employer denied compensability of claimant's condition. (Ex. 55-1). Claimant subsequently filed a request for hearing. In late January 1991, claimant's symptoms became acute and disabling, requiring hospitalization for about two weeks. (Exs. 45 and 67).

Claimant's various symptoms since at least September 1990 have been due to a fungal infection called sporotrichosis. An initial sporotrichosis infection usually occurs when contact with vegetation creates an opportunity for the fungus involved, sporothrix schenckii, to enter the body through a cut in the skin. (Exs. 96-3, 98-3, and 102-27). After infectious exposure, sporotrichosis has an incubation period of from one to 12 weeks until initial symptoms appear. (Ex. 98-7). Sporothrix schenckii occurs on innumerable types of vegetation. (Ex. 98-4). Consequently, it is a well known occupationally acquired infection for nursery workers and others who work with plants.

There were plants in the yard of the house where claimant lived when he worked for the employer. However, claimant never tended the yard. Moreover, claimant had not been employed in a job involving frequent contact with plants for two years before beginning his job with the employer.

Claimant has "acquired immune deficiency syndrome" (AIDS). He has had the AIDS virus since about 1986. AIDS has significantly weakened his immune system. (Ex. 102-28).

Once sporotrichosis is contracted, its symptoms are usually confined to the initial infection site. In some people, the infection gets into the bloodstream whereby it is carried to various parts of the body. Persons so affected are said to have "disseminated" sporotrichosis.

Disseminated sporotrichosis can and does occur in persons whose immune systems are normal. It can also occur in persons whose immune systems have been weakened or damaged by AIDS or other causes. However, it is normally occupationally associated, and the frequency of its occurrence in persons with AIDS has not been established or studied.

Claimant became infected with disseminated sporotrichosis from his contact with plants while working for the employer. Claimant's damaged immune system did not cause the infection. It did, however, render claimant susceptible to having a severe case of the infection.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to prove that his fungal infection, sporothrix schenckii (sporotrichosis), was related to his work exposure. We disagree.

Claimant's symptoms from the sporotrichosis were not sudden in onset, but arose gradually over a period of time. Therefore, this claim is properly analyzed as an occupational disease, rather than an injury. O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). Accordingly, claimant must prove, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his fungal infection. 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). However, for the purpose of determining whether a worker has met the major contributing cause standard, we do not consider his susceptibility or predisposition to the disease. Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991); Rodney T. Buckallew, 44 Van Natta 358 (1992).

Sporotrichosis is a fungus associated with plants, such as moss and roses. The fungus, which is ubiquitous in the environment, enters the body through trauma to the skin, such as that caused by contact with a thorny plant. Claimant testified that he had contact on the job with thorny plants and was frequently scratched by them during the period of his employment with the employer. Although claimant's house had a yard with plants during the time he worked for the employer, he never worked in the yard. (Tr. 146; 147). Furthermore, claimant had not been employed in a job involving contact with plants for two years prior to beginning his employment with the employer.

The record contains two medical opinions which address the causation of claimant's disseminated sporotrichosis. Dr. Gilbert is a specialist in infectious diseases who did a records review of the case for the employer. Dr. Goodpasture, also a specialist in infectious diseases, treated claimant for his sporotrichosis infection.

Dr. Gilbert believed that the sporotrichosis infection was an opportunistic infection which resulted because of claimant's damaged immune system. Dr. Gilbert explained that an exposure to sporotrichosis, in a person with a normal immune system,/would cause a relatively minor local cutaneous sporotrichosis. However, Gilbert indicated that in a patient with a damaged immune system, such as claimant, the fungus causes the more serious disseminated sporotrichosis by gaining entrance into the blood stream and spreading to skin, muscle, and joints throughout the body. Dr. Gilbert acknowledged that landscapers and others who work around plants have an increased risk of contracting sporotrichosis, but opined that it was impossible to say where claimant contracted the sporotrichosis. Dr. Gilbert opined that the major contributing cause of claimant's disseminated sporotrichosis was AIDS.

On the other hand, Dr. Goodpasture explained that sporotrichosis, both the local and "disseminated" variety, is a well known occupationally acquired infection of nursery workers and others who work with plant materials. Dr. Goodpasture was aware of the nature of claimant's work activities

for the employer and concluded that claimant acquired the sporotrichosis infection as a result of those work activities. Dr. Goodpasture did not agree with Dr. Gilbert's opinion that disseminated sporotrichosis was an AIDS defining opportunistic infection. Dr. Goodpasture explained:

> "[Claimant] does have AIDS as defined by a very, very low T4 cell count and he would have also had an AIDS-defining T4 count in 1990 based on what information we have about the decline of T4 cells over time in individuals chronically infected with HIV. On the other hand, I would not regard disseminated sporotrichosis as an 'AIDS-defining opportunistic infection' since this is an infection that is acquired exogenously (not as a result of relapse of previously dormant disease) and certainly is an infection that is well known to occur in patients who do not have AIDS and, in fact, whose immune systems are normal by all the tests we can make * * * In short, sporothrix schenckii, is not regarded as an 'opportunistic pathogen.'" (Emphasis in original).

Finally, Dr. Goodpasture indicated that claimant's AIDS was a predisposing factor, rather than a causal factor in relation to claimant's infection. In this regard, Dr. Goodpasture stated: "I have no doubt that [claimant] has had more problems with his infection because of his acquired immune deficiency syndrome. However, it is clear to me that the acquired immune deficiency syndrome is a predisposing condition which made his disease worse. If he had not been involved in the employment conditions as he was, it is unlikely that he would have developed disseminated sporotrichosis * * *" (Emphasis supplied).

We find Dr. Goodpasture's opinion to be both well reasoned and based on complete information. Accordingly, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986). Thus, we accept Dr. Goodpasture's opinion that claimant acquired the sporotrichosis infection at work through exposure to plants. We further accept Dr. Goodpasture's opinion that the sporotrichosis infection is not an opportunistic infection which lay dormant in claimant's body and became active as a result of his AIDS condition, but rather stems from an outside exposure to the fungus at work. Finally, we accept Dr. Goodpasture's opinion that claimant's damaged immune system did not cause the infection. Rather, it rendered claimant susceptible to having a severe case of the infection.

Consequently, claimant's symptoms became worse than they otherwise might have been had his immune system not been damaged by AIDS. Therefore, we find that claimant's damaged immune system was a predisposition or susceptibility to having a bad case of the infection, once the infection was contracted as a result of the work exposure. Because it is a predisposition rather than a cause, we do not consider claimant's AIDS in determining whether he has carried his burden of proving that work activities were the major contributing cause of his infection. See Liberty Northwest Ins. Corp. v. Spurgeon, supra; John E. Perkins, 44 Van Natta 1020 (1992).

Based on this record, and particularly in light of Dr. Goodpasture's persuasive opinion, we find that claimant has established that his employment activities were the major contributing cause of the disseminated sporotrichosis infection. Thus, claimant has established compensability of his sporotrichosis infection as an occupational disease.

In reaching this conclusion, we note that we are finding only the disability and treatment related to claimant's sporotrichosis condition compensable. Claimant does not contend that his underlying AIDS condition was pathologically worsened by his work exposure.

Finally, we wish to emphasize that we are not holding that a damaged immune system from AIDS will always be considered a predisposition, rather than a cause of a contested work-related condition. Likewise, we are not finding that AIDS is a condition for which every workers' compensation carrier for every infected worker will be responsible. Rather, we are concluding that in this particular case, under these specific circumstances, the employer is responsible for claimant's disability and treatment attributable to his disseminated sporotrichosis condition (for which he was rendered more susceptible to contracting by virtue of his AIDS-damaged immune system). On this latter point, we would further note that, given our conclusion that the damaged immune system in this case constituted a predisposition, the origin of that damage is not critical to our analysis as to whether claimant's work activities were the major cause of his sporotrichosis condition. In other words, claimant's predisposed damaged immune system could have been attributable to diabetes, influenza or some other condition affecting the immune system, and our conclusion on this record would remain unaltered.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 $4,000, 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 appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 22, 1992 is reversed. For services at hearing and on review, claimant's attorney is awarded $4,000 payable by the self-insured employer.

**Member Kinsley, specially concurring.**

I agree with the majority that this claim is compensable. However, I write separately because I do not consider claimant's AIDS as a "predisposition" in these circumstances.

While I agree that Dr. Goodpasture's opinion is persuasive, I interpret it differently than the majority. I understand Dr. Goodpasture' opinion to mean that, although AIDS rendered claimant susceptible to having a more severe case of sporotrichosis once contracted, AIDS neither caused the sporothrichosis nor predisposed claimant to contracting the disease. Therefore, because AIDs was not a cause of the compensable disease nor a "predisposition" in causing that condition, I would not consider it in analyzing the initial compensability of claimant's claim for sporotrichosis. Accordingly, I find that Liberty Northwest Ins. Corp. v Spurgeon, 109 Or App 566 (1991) and Rodney T. Buckallew, 44 Van Natta 358 (1992), which deal with the treatment of predispositions in calculating the relative weight of off-the-job and on-the-job causes, to be inapplicable in these circumstances.

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In the Matter of the Compensation of
**MARSHALL E. WINGARD, Claimant**
WCB Caase No. 91-16328
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of that portion of Referee Myzak's order that awarded claimant's counsel an assessed attorney fee of $4,000 for services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On reconsideration, the Referee increased claimant's attorney fee from $2,500 to $4,000. We modify.

The employer contends that this was not an overly complex case as the issue at hearing involved whether claimant's degenerative disc disease was compensably related to his 1978 injury. The employer also argues that the benefit to claimant is reduced as the claim is in "Own Motion" status. See Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd Weyerhaeuser Co. v. Fillmore, 98 Or App 567 (1989); Derry D. Blouin, 35 Van Natta 570 (1983) (successful results obtained in medical services claim are generally considered to be rather modest).

Claimant contends that the case was complex as it involved multiple injuries between the time of the 1978 injury and the onset of his current condition. Claimant also argues that his attorney is highly skilled and there was a significant risk that the claim would be found not compensable and counsel's efforts would go uncompensated.

After reviewing the documentary evidence and the transcript, we agree that an attorney fee award of $4,000 is excessive in this case. 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 $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to this case as represented by the length of the hearing and claimant's counsel's statement of services, the complexity of the issue (degenerative disc disease), and the value of the interest involved.

ORDER

The Referee's order dated March 9, 1992, as amended by the March 12, 1992 order and reconsidered by the March 26, 1992 order, is modified in part. The Referee's attorney fee award of $4,000 is modified. In lieu of the Referee's award, claimant's counsel is awarded a reasonable assessed attorney fee of $3,000, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**JAMES E. ADAMS, Claimant**
WCB Case No. 92-01184
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Brown's order that affirmed an Order on Reconsideration which awarded no unscheduled or scheduled permanent disability. On review, the issue is extent of unscheduled and scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt his Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, although claimant had a chronic bilateral upper extremity overuse syndrome which limited repetitive use of both shoulders and forearms, he had no measureable impairment under the "standards," and was therefore not entitled to an award of permanent disability. In arriving at his conclusion, the Referee relied upon the case of William K. Nesvold, 43 Van Natta 2767 (1991).

On review, claimant contends that a chronic condition award may be made even though there have been no other values assigned for impairment. Claimant notes that OAR 436-35-010(6), the chronic condition rule provides, in part:

> "A worker may be entitled to a scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow and arm.

> "(a) Scheduled chronic condition impairment is considered after all other scheduled impairment, if any, has been rated under these rules and converted, pursuant to OAR 436-35-120 and/or 436-35-240 to the appropriate body part proximal to the body." (Emphasis added).

OAR 436-35-010(6). Also see OAR 436-35-320(5)(a).

Claimant also contends that Nesvold is distinguishable from the present case because the record in Nesvold contained no medical opinion documenting loss of repetitive use. We agree with claimant that Nesvold is distinguishable.

In Nesvold, the claimant's treating doctor stated that the claimant had fully recovered and had no impairment from a minor strain. Furthermore, the claimant in Nesvold attempted to establish his entitlement to an award of permanent disability by testifying to his chronic condition. We therefore concluded that claimant had not established impairment as measured by a physician, which the standards require before an award of disability is allowed.

However, in the present case the Referee found, and we agree, that the preponderance of medical evidence establishes that claimant is unable to repetitively use his upper extremities, due to his chronic bilateral condition. Accordingly, we conclude that claimant's decrease in function of a body part has been measured by a physician and, therefore, fits within the standards' definition of "impairment." OAR 436-35-005(5).

In rating claimant's permanent impairment, we apply the "standards" in effect at the time of the June 19, 1991 Determination Order. WCD Admin. Order 2-1991.

Unscheduled permanent disability

Age/Education

The appropriate value for claimant's age of 29 years is 0. OAR 436-35-290(1).

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

The highest specific vocational pursuit demonstrated by claimant during the ten years preceding the time of determination was as a material coordinator (DOT #221.167-014). Therefore, the appropriate value for skills is 2. OAR 436-35-300(4).

Here, claimant has an SVP of 6 for the ten years preceding the time of determination. Accordingly, no additional value is allowed for training. OAR 436-35-300(5).

Adaptability

At the time of injury, claimant was performing medium work as a hydraulic cylinder assembly person. The Referee found that claimant had returned to work as a material coordinator, which is light work.

On review, claimant argues that the record establishes that he was not able to successfully perform the light work and was only capable of performing work in the sedentary category. Claimant cites to the opinion of Dr. Young who reported that claimant was forced to live a "sedentary existence." (Ex. 7A).

We are not persuaded by claimant's argument. Dr. Young's reference to a sedentary lifestyle does not necessarily address claimant's work capacity as defined under the "standards." Moreover, claimant's testimony does not establish that he was unable to perform his modified work. Accordingly, we agree with the Referee's finding that claimant returned to light work as a materials coordinator. Therefore, the appropriate adaptability value is 3. OAR 436-35-310(3).

Impairment

On review, SAIF contends that even if claimant is awarded a 5 percent value for chronic condition limiting repetitive use of the right shoulder, he is not entitled to a value for his left shoulder as that was not accepted as part of the claim. We disagree.

Claimant's Form 801 listed the affected body part as "left" and "right" hand, wrist, and arm. In addition, we find that the medical evidence establishes compensability of claimant's upper extremities, which includes his shoulders. (Ex. 7-A, 8-2, 11-1). Accordingly, we agree with claimant that Dr. Young's October 22, 1990 report establishes that claimant is entitled to a 5 percent chronic condition award for each shoulder. OAR 436-35-320(5).

Claimant's unscheduled chronic condition impairment awards of 5 percent for the left shoulder and 5 percent for the right shoulder are combined, for an impairment value of 10 percent. OAR 436-35-320(5).

Having determined each value necessary to compute claimant's permanent disability award under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 2, the sum is 2. When that value is multiplied by claimant's adaptability value, 3, the product is 6. When that value is added to claimant's impairment value, 10 percent, the result is 16 percent unscheduled permanent partial disability. Claimant's unscheduled permanent disability under the "standards" is, therefore, 16 percent.

Scheduled Permanent Disability

Consistent with our above reasoning, we find that claimant has established that he is unable to repetitively use his wrists, due to his chronic, permanent bilateral carpal tunnel condition. Accordingly, claimant is entitled to an award of 5 percent scheduled permanent disability for the right wrist and 5 percent scheduled permanent disability for the left wrist.

ORDER

The Referee's order dated May 8, 1992 is reversed. In lieu of the Referee's order and Order on Reconsideration and in addition to the Determination Order award of 13 percent (41.6 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award to date of 16 percent (51.2 degrees). The Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use of the left forearm and 5 percent (7.5) degrees scheduled permanent disability for loss of use of the right forearm, is reinstated and affirmed. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's counsel by the SAIF Corporation. However, the total attorney fee award shall not exceed $3,800.

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January 14, 1993 Cite as 45 Van Natta 61 (1993)

In the Matter of the Compensation of
**LONNIE R. BARNES, Claimant**
WCB Case No. 91-13979
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Howell's order that declined to award claimant additional unscheduled permanent disability beyond the 4 percent (12.8 degrees) granted by an Order on Reconsideration. On review, the issue is extent of unscheduled permanent disability.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing, contesting a reconsideration order award of 4 percent unscheduled permanent disability. The Referee declined claimant's request for an increase. Noting that the only impairment findings present in the record were provided by California physicians, the Referee concluded that there was no evidence upon which he could rely to determine claimant's injury-related

impairment. Consequently, the Referee reasoned that he could not make a "finding of, or award, permanent disability."

Claimant objects to the Referee's reasoning, contending that it is permissable to consider all medical evidence when evaluating permanent disability. We decline to address the Referee's reasoning because, even if the California physicians' findings/opinions are considered, we are not persuaded that claimant's unscheduled permanent disability award for his July 1989 compensable injury exceeds 4 percent.

Claimant asserts that the impairment findings made by Dr. Vandernoot (a California orthopedist who performed an independent medical examination), as concurred in by Dr. Miller (claimant's former treating physician in California), should be considered. Based on Vandernoot's findings, claimant's low back impairment would be 9 percent for a two disc surgical procedure (unresolved from a prior 1984 compensable injury) and 2.5 percent for reduced lumbar spine motion. OAR 436-35-350(2)(a); OAR 436-35-360 (7), (9). When combined, these values equal 12 percent. OAR 436-35-360(23).

Claimant's age of 45 years entitles him to a value of 1. OAR 436-35-290(2). He has a high school education, for which the value is 0. OAR 436-35-300(3)(a). The highest SVP for a job claimant performed within the last 10 years preceding the May 1991 Determination Order is 4 (a truck driver). (Parenthetically, we note that claimant was employed as a diesel mechanic helper (SVP - 4) rather than a diesel mechanic (SVP - 7)). An SVP of 4 equals a value of 3. OAR 436-35-300(4)(e). Since claimant has a current drivers license, he is not entitled to an additional value of 1. See OAR 436-35-300(5).

The strength demands of claimant's truck driver job were medium and he is now limited to light duty activities. Consequently, he is entitled to an adaptability value of 3. OAR 436-35-310(3). When claimant's age, education, and skill values are totalled, they equal 4. Multiplying that value by claimant's adaptability value (3) equals 12. When that value is added to claimant's impairment value (12), the total is 24 percent.

Claimant is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the current injury, but which has already been compensated by an earlier award. Mary A. Vogelaar, 42 Van Natta 2846 (1990). Thus, when determining claimant's loss of earning capacity attributable to his July 1989 compensable injury, we consider his 20 percent permanent disability award resulting from his 1984 injury. Claimant underwent low back surgery at two levels because of his 1984 injury. His current injury was accepted as a lumbar strain and his current low back condition has been diagnosed as resolved sprain/contusion and preexisting degenerative arthritis and spondylosis.

In light of such circumstances, we conclude that claimant's loss of earning capacity prior to his 1989 compensable injury was 20 percent. Since claimant's permanent disability under the standards equals 24 percent, we hold that the 4 percent awarded by the reconsideration order appropriately compensates claimant for his 1989 compensable injury.

Finally, claimant also seeks an award for a cervical spine injury. Yet, as mentioned above, claimant's claim was accepted as a lumbar strain. Moreover, preexisting cervical spondylosis and disc disease has been identified. Finally, notwithstanding claimant's subjective neck complaints, no reduced range of motion findings nor any other measurable impairment were registered. Accordingly, we are not persuaded that claimant suffered permanent cervical impairment resulting from the 1989 compensable injury.

## ORDER

The Referee's order dated May 4, 1992 is affirmed.

In the Matter of the Compensation of
**ALFRED MOTA, Claimant**
WCB Case No. 91-16716
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller, Brazeau and Neidig.

Claimant requests review of Referee Bethlahmy's order which found that he had not established good cause for failing to timely file his request for hearing. On review, the issue is timeliness. We reverse and remand.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last sentence in that section. We add the following supplementation.

Claimant was injured on May 24, 1991. The self-insured employer's denial was issued July 27, 1991.

Claimant's attorney's office completed a request for hearing on August 13, 1991, and the attorney signed the request on that date.

On November 22, 1991, claimant's counsel's secretary called the Hearings Division and was informed that claimant's request for hearing had never been received. A request for hearing was then mailed on November 22, 1991, and was received by the Hearings Division on November 25, 1991.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness

The Referee found that claimant had failed to establish "excusable neglect" on the part of his attorney or the attorney's employee who was responsible for mailing the request for hearing. Accordingly, she concluded that claimant had failed to establish good cause for his untimely filing of the request for hearing. We disagree.

A request for hearing must be filed no later than the 60th day after claimant is notified of a denial. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). While the neglect of an attorney's employee who is not responsible for handling hearing requests may be excusable neglect, see Brown, supra at 460, neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. See Sekermestrovich v. SAIF, 280 Or 723 (1977); EBI Companies v. Lorence, 72 Or App 75 (1985).

Here, claimant did not request a hearing on the July 27, 1991 denial until November 25, 1991, which is more than 60 days but less than 180 days after the employer's denial. At hearing, claimant's attorney's legal secretary testified that she was the person responsible for filing requests for hearing. The secretary had prepared a request for hearing on August 13, 1991, as indicated by a computer printout. (Ex. 18).

The attorney's secretary testified that, in the normal course of business, she would have prepared a hearing request after receiving dictation from the attorney. She would then have either claimant's counsel or another attorney in the office sign the hearing request. Finally, her normal

procedure was to either deliver the request personally to the mailroom or to put it in a bin where it would be picked up by a mail clerk.

Although claimant's attorney's secretary was unable to remember specifically what she had done with claimant's request for hearing, we conclude that the record establishes that she did not neglect to file the request. Our conclusion is based upon the evidence of the printout which establishes that the secretary did prepare the hearing request. (Ex. 18). Additionally, the hearing request was signed by claimant's counsel, (Ex. 17), and a memo to claimant's file provides that the request was filed on August 13, 1991. (Ex. 20). Finally, the secretary testified that her standard procedure was to either deliver the request for hearing to the mailroom or to place it in a bin for mailing by a clerk.

Under the circumstances, we conclude that the record establishes by a preponderance of the evidence that claimant's attorney's secretary did not neglect to file the hearing request. Therefore, subsequent neglect or misdirection of the hearing request once it was in the mail stream, if any, cannot be attributed to a person charged with the responsibility of filing the request (i.e., claimant's counsel or counsel's secretary). See e.g. Brown v. EBI Companies, supra.

In arriving at our conclusion, we find that the present case is distinguishable from Pedro Mendoza, 44 Van Natta 247 (1992), which is cited in the employer's brief. In Mendoza, supra, the legal assistant responsible for filing hearing requests admitted that she had misfiled a diary card and that, for various personal reasons, she had failed to file the claimant's request for hearing before the 60-day deadline. In this case, however, the legal secretary took every step necessary to file the request for hearing, and there is no evidence that the failure of the Board to receive the hearing request was attributable to any of her actions or inaction. Accordingly, we disagree with the employer's contention that the holding in Mendoza controls the outcome of the case.

We conclude that claimant has established good cause for the untimely filing of his hearing request. Because the Referee did not alternatively address the merits of the case, we find that the record is insufficiently and inadequately developed for purposes of review. ORS 656.295(5). Accordingly, we grant claimant's request and remand this matter to Referee Bethlahmy for a hearing on the merits. The Referee may conduct the hearing in any manner that shall achieve substantial justice.

ORDER

The Referee's order dated March 31, 1992 is reversed. Claimant's request for hearing is reinstated. This matter is remanded to Referee Bethlahmy for further proceedings consistent with the order.

**Board Member Neidig dissenting.**

The majority has found that claimant has established good cause for the untimely filing of his hearing request. I disagree.

Neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. Sekermestrovich v. SAIF, 280 Or 723 (1977). Here, there is no dispute that claimant's attorney's secretary was the person responsible for the filing of hearing requests. Furthermore, the Referee found that the secretary was unable to specifically recall what had been done with claimant's request for hearing.

The majority assumes that the secretary must have properly dealt with the hearing request because her standard procedure was to deliver the hearing requests to the mailroom or to place the requests in a bin for mailing. The majority also assumes that any neglect must have subsequently befallen the request while it was in the mail stream. However, assumptions are not adequate to establish claimant's burden of proving that the untimely filing was due to the excusable neglect of someone in the mailroom who was not responsible for handling hearing requests. See Ronald L. Schilling, 42 Van Natta 2566 (1990), aff'd mem Schilling v. Brothers Landscaping et al, 109 Or App 494 (1991). Here, the testimony of the legal secretary who was responsible for handling the requests falls short of establishing that she had completed her assigned duty and had placed the request in the mail stream of either the office or the U.S. Postal system.

Under such circumstances, I would affirm the Referee and find that claimant has failed to establish good cause for the untimely filing of his request for hearing.

In the Matter of the Compensation of
**ANDREW A. SANDERS, Claimant**
WCB Case Nos. 91-14714 & 91-13878
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cummins, et al., Defense Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation (on behalf of Metal Masters Incorporated) requests review of Referee Mongrain's order that: (1) set aside its denial of claimant's aggravation claim for his current upper extremity condition; and (2) upheld SAIF 's denial (on behalf of Al's Window and Carpet) of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee concluded that claimant had established a compensable aggravation claim with SAIF/Metal Masters. On review, Metal Masters argues that the September 17, 1990 award of unscheduled permanent disability anticipated waxing and waning of symptoms. Metal Masters contends that claimant's increased symptoms were not more than the waxing and waning of symptoms contemplated by the prior award. We agree.

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 upper extremity 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 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.

Prior to claim closure, claimant had been released to return to light work. His treating doctor, Dr. Johnson, M.D., noted that claimant had reinjured his neck and continued to suffer occasional recurrences of muscle strain and spasm after the activities of normal living. Dr. Johnson opined that the residual effects of claimant's injuries would consist of "similar future episodes."

At the time of closure, claimant was working at light duty as a salesperson, and had problems if he tried to lift anything heavy. Furthermore, prior to closure, the Western Medical Consultants diagnosed chronic cervical sprain with myofascial pain syndrome. They noted that claimant was "functioning satisfactorily in his current position" and had increased symptoms when he tried to exceed the recommended guidelines. The Consultants noted that he was not on any curative treatment program, and that his treatments were palliative, with no major change in his underlying condition anticipated. (Ex. 9-4).

Following claimant's increased symptoms on August 27, 1991, Dr. Perry, M.D., reported that claimant had had an aggravating injury to the right shoulder with recurrent symptoms similar to his previous injury. Therapy of four to six weeks was suggested and Dr. Perry recommended that claimant

continue to limit his work to light duty. On October 21, 1991, Dr. Perry recommended that claimant could return to work as long as he limited his shoulder activities to less than "50 lbs. repetitive."

On December 19, 1991, claimant was examined by the Medical Consultants Northwest. The Consultants opined that claimant's increased pain was a waxing and waning of preexisting symptoms. The Consultants arrived at their opinion after considering the opinions of claimant's treating physicians, the location of his pain and the fact that claimant's condition "responded as the previous episodes had responded." (Ex. 23-2). Dr. Baker, one of the Consultants, opined that claimant had experienced prior waxing and waning of symptoms in the past, and would continue to "have waxing and waning in the future."

On December 30, 1991, Dr. Dickerman, who had first examined claimant in 1989 following his compensable injury, reviewed claimant's file and opined that claimant had experienced a flare-up of symptoms in August 1991. He reported that claimant had underlying myofascial pain syndrome and certain activities would trigger increased symptomatology. Dr. Dickerman stated that there was no evidence from the records that there had been any actual worsening of his condition. (Ex. 24-3).

Finally, on December 30, 1991, Dr. Perry, claimant's treating orthopedic surgeon, signed a concurrence letter indicating that, as a result of claimant's work activity in August 1991, he had experienced a brief and temporary worsening of his subjective complaints, rather than a pathologic worsening of his underlying condition. Dr. Perry also concurred that claimant's increased complaints were consistent with the anticipated waxing and waning of his chronic condition. (Ex. 25).

Dr. Perry subsequently testified that he had earlier believed claimant had minimal impairment, and he continued to believe, in September 1991, that claimant had minimal impairment. Although Dr. Perry acknowledged that claimant had greater subjective complaints, he stated that he believed that claimant tended to embellish his subjective complaints. (Ex. 26-30).

After reviewing the medical evidence, we conclude that claimant has failed to establish 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 of compensation. Accordingly, claimant has failed to establish a compensable aggravation.

Responsibility

We agree with and adopt that portion of the Referee's "Opinion" which concludes that, pursuant to ORS 656.308(1), responsibility for claimant's condition remains with SAIF/Metal Masters Incorporated pursuant to the accepted April 10, 1989 injury claim.

ORDER

The Referee's order dated May 11, 1992 is reversed in part. That portion of the Referee's order that set aside the SAIF Corporation's aggravation denial, on behalf of Metal Masters, is reversed. SAIF's denial on behalf of Metal Masters is reinstated and upheld. The Referee's attorney fee award of $2,500 is also reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**LARRY L. TABOR, Claimant**
WCB Case Nos. 90-15413, 90-15253, 91-08004 & 91-08005
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Black's order that: (1) found that claimant's aggravation rights ran from the December 2, 1987 Determination Order; and (2) upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome. On review, the issues are the aggravation date, the res judicata effect of a prior Determination Order and compensability.

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

On review, claimant argues that the first determination of his 1985 injury claim was March 7, 1990, the date the second Determination Order issued rather than December 2, 1987 (the date of his first Determination Order). We disagree. The December 2, 1987 Determination Order was never set aside and has become final by operation of law. Inasmuch as the December 2, 1987 Determination Order represents the first determination of claimant's injury claim, claimant had 5 years from that date within which to file an aggravation claim. ORS 656.273(4)(a).

Claimant argues that Paul E. Voeller, 42 Van Natta 1775, on recon, 42 van Natta 1963 (1990) requires a different result. We disagree. In Voeller, a prior referee issued an order finding a psychological condition compensable. The employer subsequently requested that the claim be closed even though the psychological condition had not yet become medically stationary. The claim was closed by Determination Order. The Determination Order was appealed and a second referee found the claim prematurely closed and set aside the Determination Order. On appeal, the Board affirmed the second referee's order. Voeller has no application here since it does not involve a situation, like the present one, where a Determination Order has become final as a matter of law and where a claimant has subsequently requested a hearing on an issue finally decided by that Determination Order.

Compensability of Bilateral Carpal Tunnel Syndrome

We adopt the reasoning and conclusions of the Referee regarding the compensability of the bilateral carpal tunnel syndrome.

ORDER

The Referee's order dated February 7, 1992 is affirmed.

In the Matter of the Compensation of
**ANNE M. YOUNGER, Claimant**
WCB Case No. 92-01794
ORDER ON REVIEW (REMANDING)
Black, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Brown's order that set aside an Order on Reconsideration as invalid. On review, the issue is the validity of the Order on Reconsideration. We remand.

## FINDINGS OF FACT

We adopt the Referee's "Findings," with the following supplementation.

Claimant's request for reconsideration was received by the Department on November 7, 1991.

The Referee's order was issued on May 7, 1992.

We take administrative notice of the fact that, on November 16, 1992, claimant received a letter from the Department which stated that the medical arbiter exam of January 8, 1992 was not complete at the time the Department issued its Order on Reconsideration. Thus, the Department announced that another arbiter exam was being rescheduled. We also take administrative notice that a November 16, 1992 letter from the Department to the medical arbiter stated that, because his prior report did not address lumbar ranges of motion, a supplemental examination of claimant was required.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because the medical arbiter failed to perform range of motion tests during claimant's exam, the arbiter's report was not competent for purposes of determining claimant's impairment. Relying on Olga I. Soto, 44 Van Natta 278 (1992), the Referee concluded that the Department's inability to obtain an adequate arbiter's report was equivalent to not appointing an arbiter at all. The Referee therefore concluded that the Order on Reconsideration was not valid. We disagree.

Here, claimant disagreed with the impairment findings of her treating physician and a medical arbiter exam was scheduled according to ORS 656.268(7). In January 1992, Dr. Wilson, an out-of-state medical arbiter, examined claimant but declined to perform range of motion testing, as in his opinion, "subjectivity is too great to establish an impairment rating based on emotion that can be controlled by the patient." (Ex. 29). Dr. Wilson also reported that, typically, he would "close a case of this type with no impairment...."

On review, claimant argues that Dr. Wilson's failure to perform range of motion testing is contrary to the Department's instructions to medical arbiters which explain that, as of April 1, 1991, the inclinometer method of measuring spinal ranges of motion will become the new standard. Claimant also argues that the Department's Bulletin No. 242, which issued November 22, 1991, provides the arbiters with methods of measuring spinal ranges of motion.

We conclude that, although claimant disagrees with the manner in which the arbiter's exam was conducted, the fact is that an arbiter was appointed and an examination was performed consistent with ORS 656.268(7). The statute specifies only that the medical arbiter "may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment." Here, the arbiter apparently did not believe that claimant had any permanent impairment. Additionally, although the arbiter's opinion regarding range of motion tests may vary from the AMA guidelines or the Department's recommendations, we conclude that such factors go to the persuasiveness of the opinion. See e.g. Timothy W. Reintzell, 44 Van Natta 1534 (1992) (impairment is established by the preponderance of medical evidence).

Accordingly, we do not find that the arbiter's failure to perform range of motion findings is equivalent to a situation in which no medical arbiter has been appointed. Furthermore, we conclude that if an arbiter appointed by the Department fails to perform an examination in a satisfactory manner, the Department is capable of correcting such situations by either clarifying instructions to the arbiter or by rescheduling another arbiter before it issues its Order on Reconsideration.

In the present case, claimant's request for reconsideration was made after October 1, 1991. Accordingly, ORS 656.268(6)(a) applies to this case. The statute provides, in pertinent part:

> "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

Under the circumstances, we conclude that, because the statute permits the receipt of such a report at hearing, and because the Department has conceded that the arbiter exam in this case was incomplete, and has instructed the medical arbiter to perform a supplemental exam, a compelling reason exists to remand this matter to the Referee. ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Accordingly, we find that the Order on Reconsideration is valid but for the aforementioned reasons, we remand this case to Referee Brown. In remanding this matter, we reiterate that the Referee may receive the supplemental arbiter's report as evidence, pursuant to ORS 656.268(6)(a). Further proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated May 7, 1992 is vacated. This matter is remanded to Referee Brown for further proceedings consistent with this order.

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January 15, 1993 Cite as 45 Van Natta 69 (1993)

In the Matter of the Compensation of
**DONALD A. MARK, SR., Claimant**
WCB Case Nos. 91-09598 & 91-15497
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Livesley's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. Noting that Liberty's appellant's brief concedes that no medical evidence relates claimant's current condition to its 1984 compensable injury with the SAIF Corporation, SAIF seeks its dismissal as a party to this proceeding. On review, the issues are motion to dismiss and compensability.

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

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

If the Referee's decision is contained in a final order and that order is appealed, we retain jurisdiction to consider all matters contained therein. Jerry R. Miller, 44 Van Natta 1444 (1992); William E. Wood, 40 Van Natta 999 (1988). Therefore, if a party has not been dismissed from a proceeding and

it is a party to the appealed Referee's order, it is considered a party for purposes of Board review. Jerry R. Miller, supra.

Here, SAIF argues that it should be "dismissed from this claim" because "Liberty Northwest concedes that none of the medical experts relate claimant's current degenerative arthritis to claimant's 1984 shoulder injury." Therefore, SAIF contends that the only issue on appeal is whether the major contributing cause of claimant's current condition was his work exposure after Liberty Northwest because the insurer on risk for the employer in 1984.

It does appear that Liberty contested only compensability of its claim on Board review. Nevertheless, the Referee's order also concerned claimant's hearing request from SAIF's denial of claimant's claim. Inasmuch as SAIF was a party to the Referee's order, and since Liberty has requested Board review of that order, SAIF must remain a party on Board review.

We adopt the Referee's "Conclusions of Law and Opinion" on the issue of compensability with the following supplementation.

In holding that claimant's right shoulder condition was compensable as an occupational disease, the Referee relied on the opinion of Dr. Schachner, the treating physician. On review, the insurer contends that Schachner's opinion is not probative, because it is based on an exclusion of possible causes.

A claimant cannot carry his burden of proof "merely by disproving other possible explanations of how the injury or disease occurred." ORS 656.266. The record reveals, however, that in addition to ruling out the other potential causes of claimant's right shoulder condition, including the 1984 shoulder strain or a traumatic event, Schachner considered claimant's medical history and work activities. Based on those considerations, Schachner concluded that the major contributing cause of claimant's right shoulder condition was his repetitive work activities after May 1984. Therefore, contrary to Liberty's contention, Schachner provides an affirmative causal link between claimant's work and his need for treatment. Based on that persuasive opinion, we agree with the Referee that claimant has established a compensable claim.

Inasmuch as Liberty 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 Board review concerning the compensability issue is $750, to be paid by Liberty. 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 3, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney of $750, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
**ANASTACIO L. DURAN, SR., Claimant**
WCB Case No. 91-17079
ORDER ON REVIEW
Jeff J. Carter, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee T. Lavere Johnson's order that: (1) found that claimant had timely filed his request for hearing; (2) set aside its denial of claimant's left elbow claim; and (3) awarded a $2,500 assessed attorney fee. On review, the issues are timeliness, compensability, and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact except for the finding that: "Claimant received actual notice of the denial of July 18, 1991, on November 20, 1991, after a second mailing for which he signed."

## CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim on April 24, 1991. The employer's claim processor denied the claim by letter dated July 18, 1991. On July 19, 1991, the denial arrived at claimant's residence by certified mail. Claimant's daughter, who was visiting, signed for the letter and placed it, along with the other mail, on a table. She did not personally advise claimant of the letter. Claimant testified that he was not actually aware of the denial until Dr. Stringham, his treating physician, informed him of it on November 18, 1991. He testified that he then called the employer's office and, on November 20, 1991, received a copy of the denial. Claimant filed a request for hearing on November 21, 1991.

The employer first challenges the Referee's finding that claimant timely filed his claim. It asserts that, because claimant's daughter received the denial letter on behalf of claimant, claimant had constructive knowledge of the denial. We agree.

ORS 656.319(1) provides that, upon claim denial, "a hearing thereon shall not be granted and the claim shall not be enforceable unless:

> "(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial or;
>
> "(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at hearing that there was good cause for failure to file the request by the 60th day after notification of the denial."

The 60-day and 180-day periods begin running when claimant receives actual or constructive receipt of the denial. SAIF v. Edison, 117 Or App 455 (1992). Furthermore, we have held that a claimant has constructive knowledge if, unbeknownst to the claimant but on the claimant's behalf, a relative receives and signs for a certified letter correctly addressed notifying the claimant of the denial. James R. Barnett, 44 Van Natta 834 (1992). We find that, pursuant to Barnett, claimant had constructive knowledge of the denial.

Claimant argues that if we find that he did have constructive knowledge, he established "good cause" for failing to file his request for hearing within 60 days of notification and, therefore, his request was timely because he filed it within 180 days of notification. "Good cause" within the context of ORS 656.319(1)(b) means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). We agree with claimant that failure to file a request for hearing based on lack of actual knowledge of a denial is sufficient to establish "good cause" if claimant proves reasonable diligence. See Giusti Wine Co. v. Adams, 102 Or App 329, 332 (1990). For instance, in Adams, the claimant proved that he failed to actually receive a denial letter or the post office's notices regarding the letter. In James R. Barnett, supra, the claimant also proved a lack of actual

notice and reasonable diligence because he was in the process of moving; his cousin, who signed for the denial letter, did not give him the letter; and his attorney, prior to the running of the 60 days, requested from the insurer information concerning the status of the claimant's claim.

In this case, there was evidence that the denial letter was actually received by claimant's daughter and placed, along with the other mail, on a table in the house. (Tr. 37). There also was testimony that claimant's daughter previously had accepted mail for claimant in this manner and that claimant had received it. (Id. at 17, 36-39). Claimant, although stating that he did not recall not receiving any mail in the summer of 1991, (id. at 17), testified that he never saw the denial letter, (id. at 14). Therefore, unlike the claimants in Adams and Barnett, the denial letter was placed in claimant's house and claimant offered no explanation for why he failed to become aware of the letter. Furthermore, although claimant filed his claim in April 1991, he did not contact his employer regarding the status of his claim until November 1991, after he sought treatment. In view of these circumstances, we conclude that claimant failed to prove that he was reasonably diligent and, thus, he did not prove good cause for his failure to timely file his request for hearing.

Because we have found that the filing of claimant's request for review did not satisfy ORS 656.319(1), we do not address the employer's contentions regarding compensability and the reasonableness of the attorney fee awarded by the Referee.

ORDER

The Referee's order dated March 13, 1992 is reversed. The Referee's attorney fee award is reversed. Claimant's request for hearing is dismissed on the basis of untimeliness.

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January 19, 1993 Cite as 45 Van Natta 72 (1993)

In the Matter of the Compensation of
**REBECCA L. RICHARDSON, Claimant**
WCB Case Nos. 92-00728 & 92-00178
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney
Beers, et al., Defense Attorneys

EBI Companies requests reconsideration of that portion of our December 31, 1992 Order on Review that awarded claimant a penalty for the insurer's unreasonable denial of compensability. On reconsideration, EBI specifically raises three different points of disagreement with our Order on Review.

First, EBI argues that it was error for us to conclude that the SAIF Corporation's denial denied responsibility only. EBI cites SAIF's opening brief which states that it denied "compensability and responsibility for claimant's low back condition."

We are aware that SAIF's denial has been referred to as a compensability denial, both at hearing, by claimant's attorney, and in the "Statement of the Case" contained in SAIF's opening brief. However, we continue to conclude that the January 8, 1992 denial denied responsibility only. We do not find that, without an amendment of the denial at hearing, subsequent references in the record to a compensability denial change the fact that SAIF's denial was of responsibility only.

EBI next argues that claimant has waived the penalty issue as no evidence or argument was presented to the Referee on the penalty issue. We disagree.

The penalty issue was expressly raised at hearing, Tr. 2-3, and was decided by the Referee in his Opinion and Order. Moreover, claimant cross-requested review on the penalty issue. Accordingly, we find no merit to EBI's argument that the penalty issued has been waived by claimant.

Finally, EBI argues that a legitimate doubt existed as to compensability of claimant's low back condition. EBI argues that Dr. Freeman's report of December 30, 1991 stated that claimant's low back

condition was not related to her accepted claim with EBI, but was due to her present employment (i.e., with SAIF's insured). EBI contends that it was Dr. Freeman's December 1991 report upon which it based its denial.

We continue to conclude that EBI's denial of compensability was unreasonable. The rationale behind the Moyer case, relied upon in our Order on Review, is that a denial is unreasonable if the only medical evidence establishes that the claim is compensable as to at least one of the insurers. SAIF v. Moyer, 63 Or App 498, 502 (1983). Therefore, it is not relevant that Dr. Freeman's initial report suggested that the claim was compensable as to SAIF. Rather, the issue is whether Dr. Freeman's report and the remaining medical evidence indicated that claimant's condition was related to her work activity with either of the employers. We conclude that the medical evidence in the record provides no legitimate basis for contending that the claim was not compensable as to "at least one of the insurers." See OAR 436-60-180(7) (request for designation of paying agent is not an admission that the injury is compensably related to that insurer's claim). Therefore, claimant has established her entitlement to a penalty for an unreasonable denial of compensability, to be assessed against EBI.

Accordingly, our December 31, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 31, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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January 20, 1993 Cite as 45 Van Natta 73 (1993)

In the Matter of the Compensation of
**THOMAS R. KARL, Claimant**
Own Motion No. 93-0013M
OWN MOTION ORDER
Welch, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right knee injury. Claimant's aggravation rights expired on June 18, 1989. SAIF recommends that we authorize the payment of temporary disability compensation. SAIF also requests authorization for reimbursement from the Reopened Claims Reserve.

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. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning November 11, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625(b). The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**FRANK M. SAXBURY, Claimant**
WCB Case No. 92-00655
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Garaventa's order that affirmed an Order on Reconsideration award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use of the left forearm (wrist) and 7 percent (10.5 degrees) scheduled permanent disability for loss of use of the right forearm (wrist). On review, the issue is extent of scheduled permanent disability.

The Board affirms and adopt the order of the Referee, with the following supplementation.

On review, claimant asserts that he has established entitlement to a grip strength award pursuant to OAR 436-35-110(2)(a), which permits a value for loss of grip strength due to disruption of the musculotendonous unit. Claimant argues that his carpal tunnel surgery involved cutting the transverse carpal ligament.

We conclude that a grip strength award cannot be based upon inference or speculation with regard to the cause of claimant's loss, if any, of grip strength. Here, we agree with the Referee that the medical record does not establish the cause of any lost grip strength, and claimant's testimony is not sufficient in such a case. See Paul F. Wiegel, 44 Van Natta 44 (1992); OAR 436-35-005(5) (impairment under the "standards" must be measured by a physician).

ORDER

The Referee's order dated April 23, 1992 is affirmed.

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In the Matter of the Compensation of
**BONNY L. COLE, Claimant**
WCB Case No. 91-16120
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Bethlahmy's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right upper extremity condition. Submitting post-hearing medical reports diagnosing claimant's condition as impingement syndrome, claimant also requests that this matter be remanded to the Referee for further evidence taking. On review, the issues are remand and compensability. We deny the remand request and reverse.

FINDINGS OF FACT

Claimant's work activities as a painter involved repetitive traumatic use of her right upper extremity. She is right hand dominant.

In 1989, the employer installed a new painting system, which required claimant to paint from shoulder rather than waist height. Shortly thereafter, claimant developed right shoulder, wrist and hand symptoms, for which she sought treatment.

Claimant was laid off from August 1990 until June 1991. Her symptoms abated somewhat during that time, but increased when she returned to the same job. She again sought treatment and filed a claim. On October 25, 1991, the employer denied a claim for "right arm/wrist/hand pain."

Claimant has been examined by numerous physicians concerning symptoms located in her right shoulder, wrist and hand. Carpal tunnel syndrome condition, tendinitis, use/abuse syndrome, entrapment over the pronator teres in the forearm and myofascial pain have been suspected or diagnosed.

During the course of this claim, examining and treating physicians have described claimant's tenderness to palpation over the flexor aspect of the right hand; pain, burning sensation, numbness and weakness in the right hand and arm; swelling in the right hand; pain in the right wrist; positive Tinel's sign; mildly prolonged distal motor latency and palm to wrist sensory nerve conduction; diminished right grip and pinch strength; and right shoulder and trapezius pain.

Dr. Long became claimant's treating physician in December 1991. He observed clinical evidence of chronic myofascial pain involving claimant's upper trapezius muscles and right forearm flexors and extensors.

## FINDINGS ULTIMATE OF FACT

Claimant's repetitive traumatic work activities, involving her right upper extremity, were the major contributing cause of her disability and need for medical treatment for a right upper extremity condition.

The existence of claimant's right upper extremity condition is established by medical evidence supported by objective findings.

## CONCLUSIONS OF LAW AND OPINION

In order to establish entitlement to compensation for an occupational disease involving her right upper extremity, claimant must prove that her repetitive traumatic work activities were the major contributing cause of the claimed disease. In addition, the existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(1)&(2).

In order to carry the latter burden, claimant must offer 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); Todd N. Hellman, 44 Van Natta 1082 (1992). A physician's report of a worker's pain may satisfy the "objective findings" requirement if the physician's evaluation of the worker's physical condition is based on claimant's description of the pain she is experiencing. ORS 656.005(19); Suzanne Robertson, supra. Thus, to support the claim, the report must indicate that the worker does, in fact, experience the reported symptoms. Brian S. Mode, 44 Van Natta 419 (1992).

Although finding that claimant had symptoms resulting from her work activities, the Referee concluded that there were no objective findings supporting the existence of an occupational disease. Consequently, the Referee upheld the employer's denial. Inasmuch as we find claimant's claim supported by objective findings, we reverse.

The employer argues that we should rely on the opinion of Dr. Tongue, who treated claimant from September 1991 through December 1991. However, we discount Tongue's opinion that there are no clear objective findings, because his conclusion is not consistent with the legal definition of objective findings. Moreover, we find the opinions of Drs. Long and Crawford, claimant's current and former treating physicians, more persuasive because they are better reasoned. See Somers v. SAIF, 77 Or App 259 (1986).

Tongue treated claimant over a three month period. As various diagnoses were ruled out and treatment attempts failed, Tongue concluded that he had "no clear understanding of the source" of claimant's pain problem. (Ex. 13-6). Although Tongue eventually suspected functional interference, such a speculation is not borne out by the remainder of the record. The only other expert who suspected functional interference is Dr. Button, who examined claimant once. (See Ex. 15). We do not find Button's opinion to be persuasive because, although he reviewed claimant's medical records and toured her workplace, Button failed to address the potential contribution of claimant's work activities to her problems.

On the other hand, the opinions of Drs. Long and Crawford support a finding that claimant did, in fact, experience the right upper extremity symptoms for which she sought treatment. In addition, Crawford and Long persuasively explained their conclusions that claimant's symptoms are work related, considering claimant's work duties as a painter and the stance required to perform those duties. (Exs. 25, 31, 32). Crawford further noted that claimant's right upper extremity was not involved in off-work repetitive traumatic activities. (Ex. 25). In light of their familiarity with claimant's work duties, particularly Crawford's awareness of claimant's nonwork activities, we find these well-reasoned opinions to be persuasive. See Somers v. SAIF, supra.

Accordingly, based on the opinions of Drs. Long and Crawford, we conclude that claimant has established a compensable occupational disease with medical evidence supported by objective findings. Finally, even assuming that a definitive diagnosis was lacking at the time of hearing, such a circumstance would not be fatal to this claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

In light of our conclusion regarding the compensability issue, there is no compelling reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton to remand by the Board). Consequently, we deny the remand request.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,500, 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 appellate briefs and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

ORDER

The Referee's order dated March 10, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's attorney is awarded an attorney fee of $3,500, payable by the employer.

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In the Matter of the Compensation of
**CHARLES J. COLEMAN, JR., Claimant**
WCB Case No. 91-12873
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee Daughtry's order that: (1) increased claimant's scheduled disability award for a left leg (knee) condition from 11 percent (16.5 degrees), as awarded by Determination Order and Order on Reconsideration, to 16 percent (24 degrees); and (2) increased claimant's scheduled disability award for a right leg (knee) condition from 11 percent (16.5 degrees), as awarded by Determination Order and Order on Reconsideration, to 14 percent (21 degrees). In its brief, the employer also contends that the Referee erred in excluding medical reports prepared by an appointed medical arbiter. In his brief, claimant disagrees with that portion of the Referee's order that increased his scheduled permanent disability award for his left leg (knee) from 11 percent to 16 percent. On review, the issues are admissibility of evidence and extent of permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

An initial issue not raised by either party is whether the Hearings Division or the Board has jurisdiction over this matter. We have held that an Order on Reconsideration is invalid, and we therefore lack jurisdiction to consider a request for hearing concerning the Order on Reconsideration, if the basis for objection to the Determination Order is disagreement with the impairment findings used in rating the worker's disability, and the Department fails to appoint a medical arbiter and submit the arbiter's findings findings for reconsideration. See ORS 656.268(7); Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992).

However, we have also concluded that the Director's failure to appoint a medical arbiter does not render the ensuing Order on Reconsideration void ab initio. Brenton R. Kusch, 44 Van Natta 2222 (1992). Rather, it results in an order which may be voided by a party which the mandatory provision was intended to protect. Kusch, supra. Consequently, the party that requested reconsideration and objected to impairment findings may, at hearing, withdraw any objection to the impairment findings and thereby waive its right to examination by a medical arbiter. In such cases, the Order on Reconsideration is not declared invalid. See Steven E. Parker, 44 Van Natta 2401 (1992).

In the present case, at the reconsideration proceeding, claimant initially objected to the impairment findings used in rating his disability. Additionally, the Department failed to appoint a medical arbiter prior to issuing its Order on Reconsideration. However, the Referee found, and we agree, that at the time of hearing neither party objected to the validity of the Order on Reconsideration or to the Department's failure to appoint a medical arbiter. Accordingly, we find that, at hearing, claimant withdrew his objection to the impairment findings and waived his right to be examined by an arbiter. Therefore, we conclude that the Order on Reconsideration is not invalid and the Referee had jurisdiction over this matter.

Evidence

Post-reconsideration order arbiter report

On review, the employer contends that the Referee erred in excluding medical reports prepared by Dr. Stanford, the medical arbiter. The Referee refused to admit the reports because they were generated after the issuance of the Order on Reconsideration. We agree with the Referee that the reports should not be considered.

We have concluded that, with the exception of an arbiter's report pursuant to ORS 656.268(6)(a), any evidence generated after an Order on Reconsideration will not be considered. ORS 656.268(7); ORS 656.283(7); Teresa L. Erp, 44 Van Natta 1728 (1992). Here, ORS 656.268(6)(a) does not operate to permit consideration of the arbiter's report, as that amendment to the statute applies only to requests for reconsideration made on and after October 1, 1991.

Accordingly, because claimant requested reconsideration on August 21, 1991, the statute allowing medical arbiter reports into evidence at a hearing, even if the report is not prepared in time for use in the reconsideration proceeding, is not applicable. Therefore, we conclude that pursuant to the applicable law, the Referee properly declined to consider the medical arbiter's report, as it was not considered at the time of reconsideration. Finally, as explained above, we have concluded that claimant effectively withdrew his objection to the impairment findings at the time of hearing, and the employer did not oppose claimant's withdrawal of his objection. For this additional reason, we find that the Referee correctly refused to consider the arbiter's report.

Post-reconsideration attending physician reports

In rating claimant's permanent impairment, the Referee relied upon post-closure reports authored by claimant's attending physician, Dr. Jany. We have previously concluded that ORS 656.268(5) allows the submission of corrective reports and any medical evidence that should have been but was not submitted by the attending physician at the time of claim closure. See e.g. Nancy A. Worth, 44 Van Natta 2345 (1992). However, we have also found that medical evidence from the attending physician, offered pursuant to ORS 656.268(5) must be submitted at the reconsideration proceeding. ORS 656.268(5); Gary C. Fischer, 44 Van Natta 1597 on recon 44 Van Natta 1655 (1992).

Accordingly, because Exhibits 24 and 25 were not submitted at the reconsideration proceeding, we do not consider them for purposes of rating claimant's permanent disability.

Extent of scheduled permanent disability/right knee

In rating claimant's scheduled permanent disability, we apply the standards in effect at the time of the August 15, 1991 Determination Order.

Range of motion

Dr. Jany's closing report of July 21, 1991 provides that claimant has retained 135 degrees of motion in the right knee. Accordingly, claimant is entitled to an impairment value of 6 percent for loss of range of motion in the right knee. OAR 436-35-220(1).

Atrophy

We agree with the Referee that claimant is not entitled to an award for atrophy of the right knee, as he has not shown loss of strength due to nerve injury, loss of muscle or disruption of the musculotendonous unit. See OAR 436-35-230(8)-(9).

Chronic condition

We agree with the Referee that claimant has established a chronic condition as he has proven that he is unable to repetitively use his right knee. We adopt the Referee's conclusions and opinion on this issue and find that claimant is entitled to an impairment value of 5 percent for his chronic right knee condition.

Claimant's impairment value for loss of range of motion, 6, is combined with his impairment value for his chronic condition, 5, for a total impairment value of 11. Accordingly, under the standards, claimant's total scheduled award for loss of use or function of the right knee is 11 percent. Therefore, the Referee's 14 percent award is reduced.

Extent of scheduled permanent disability/left knee

Range of motion

Dr. Jany's report establishes that claimant has retained 135 degrees range of motion in the left knee. Accordingly, claimant is entitled to an impairment value of 6 percent for loss of range of motion in the left knee. OAR 436-35-220(1).

Meniscus removal

The Referee concluded that it was not certain how much of claimant's left lateral meniscus was removed during surgery. We agree with the Referee that the record as a whole establishes that claimant is entitled to an award for the surgery. However, we disagree that claimant's award should be 3 percent. As argued by claimant on review, the "standards" provide that an award for "less than complete loss of one meniscus" is 5 percent. Accordingly, we conclude that claimant is entitled to an impairment award of 5 percent for the partial meniscus removal. OAR 436-35-230(4).

Chronic condition

We agree with the Referee that claimant has established a chronic condition as he is unable to repetitively use his left knee. Accordingly, we adopt the Referee's conclusions and opinion on that issue, and find that claimant is entitled to an impairment value of 5 percent for his chronic condition.

Claimant's impairment value for loss of range of motion, 6, is combined with his impairment value for meniscus surgery, 5, for a value of 11 percent. That impairment value is then combined with claimant's value for his chronic condition for a total impairment value of 15. OAR 436-35-010(6)(c). Claimant's total scheduled permanent disability award under the "standards" for his left knee is, therefore, 15 percent. Consequently, the Referee's 16 percent award is reduced.

ORDER

The Referee's order dated February 10, 1992 is modified. In lieu of the Referee's award, but in addition to the Determination Order/Order on Reconsideration award of 11 percent (16.5 degrees) scheduled permanent impairment for the left leg (knee), claimant is awarded 4 percent (6 degrees) for a total award to date of 15 percent (22.5 degrees) scheduled permanent impairment for loss of use or function of the left leg. In lieu of the Referee's award, the Determination Order/Order on Reconsideration award of 11 percent (16.5 degrees) scheduled permanent impairment for loss of use or function of the right leg (knee) is affirmed.

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In the Matter of the Compensation of
**KURT D. CUTLIP, Claimant**
WCB Case Nos. 91-13835 & 91-12437
ORDER ON RECONSIDERATION
Westmoreland & Shebley, Claimant Attorneys
Charles A. Ringo, Defense Attorney
Miller, et al., Defense Attorneys

Crawford and Company (Crawford) requests reconsideration of that portion of our December 31, 1992 order which found it responsible for claimant's left knee condition. Crawford argues that our analysis in that order was overturned by the Court of Appeals' recent decision in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Crawford also requests that this matter be reviewed by the Board en banc.

In our prior order, we noted that claimant had an accepted left knee claim with another carrier. However, we found that a subsequent work incident which occurred after claimant began working for Crawford's insured was a material contributing cause of claimant's disability and need for treatment following the incident. Therefore, we concluded that claimant had sustained a new compensable injury involving the knee condition and that Crawford is responsible for subsequent disability and treatment pursuant to ORS 656.308(1).

Crawford argues that the court's decision in Nazari requires proof that its work exposure was the major contributing cause of claimant's disability and need for treatment. Crawford explains that claimant's prior accepted knee injury must be analyzed as a "preexisting condition" under ORS 656.005(7)(a)(B).

Crawford's argument has been rejected by the Court of Appeals in SAIF v. Drews, 117 Or App 596 (1993). The court stated that ORS 656.005(7)(a)(B) is not intended to apply in the context of assigning responsibility among successive employers for multiple compensable injuries. Id. The court explained that, in order to prove a "new compensable injury" for the purpose of shifting responsibility pursuant to ORS 656.308(1), the insurer with the most recent accepted claim has the burden of proving that the subsequent injury is a material contributing cause of claimant's disability or need for treatment. Id.

Thus, if a worker sustains a new work-related injury involving a prior compensable condition, the prior condition is not analyzed as a preexisting condition under ORS 656.005(7)(a)(B). Rather, the injury is analyzed under the "material contributing cause" test and, if the test is satisfied, responsibility shifts to the subsequent carrier. On the other hand, if the worker also suffers from a prior noncompensable condition which combines with the work-related injury to cause disability or need for treatment, ORS 656.005(7)(a)(B) is applicable and the injury must be analyzed under the "major contributing cause" test.

Here, we found that claimant had a compensable left knee condition prior to working with Crawford's insured. Therefore, we conclude that ORS 656.005(7)(a)(B) is not applicable. Based on the material contributing cause standard, we adhere to our holding that Crawford is responsible for all further disability and treatment relating to the left knee condition.

Finally, we deny Crawford's request for en banc review of this matter. While the Board may sit en banc in rendering a decision, it may also sit in panels. See Or Laws 1991, ch 954, § 3. When sitting in panels, a majority of a particular panel may issue the decision of the panel. See id. Our prior order was rendered as a panel decision by a majority of the panel. We are not persuaded that this matter should be reviewed en banc. Therefore, we decline to grant Crawford's request. See Brenda K. Allen, 44 Van Natta 2476 (1992) (on reconsideration).

Accordingly, we withdraw our December 31, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our December 31, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GENE E. ELLIOTT, Claimant**
WCB Case No. 92-01192
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Charles J. Cheek (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Brown's order that found that claimant's low back injury claim was prematurely closed. On review, the issue is premature closure. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings" and his first "Ultimate Findings of Fact," with the following supplementation.

SAIF failed to consider claimant's injury-related psychological condition upon closing claimant's low back injury claim.

## CONCLUSIONS OF LAW AND OPINION

At the outset, we note that the compensability of claimant's depressed psychological condition is not challenged on review. However, SAIF does challenge the Referee's findings and reasoning with regard to the premature closure issue.

The Referee found that claimant's low back injury claim was prematurely closed, because improvement was reasonably expected in claimant's depression on June 24, 1991, the medically stationary date established by the August 16, 1991 Notice of Closure.

The Referee reasoned:

> "The diagnosis [of depression] was established prior to claim closure. Symptoms were continuous and evidence [sic] at the time [of] Orthopaedic Consultant's [closing] examination. At best, the panel indicated that further consideration of psychiatric symptoms was necessary. Dr. Freeman concurred. [Claimant] was working only two hours per day complaining of symptoms that have been related to the diagnosis of chronic pain syndrome. It cannot be said that as of June 21 no further improvement was not expected either with treatment or time [sic]." (O&O p. 3).

Although we agree that claimant's injury claim was prematurely closed, we reach this result based on the following facts and reasoning.

On May 1, 1991, a nurse involved in claimant's work hardening program observed that claimant had seemed "more depressed" during the previous two weeks and that he reported sleeping only four hours per night. She also noted that claimant would be seeing Dr. Daskalos "for a followup office visit to assess his disturbed sleep pattern." (Ex. 5e-2).

On May 14, 1991, Dr. Freeman, treating physician, observed that claimant was depressed.

After the May 8, 1991 "Followup Visit," Daskalos, osteopath, reported:

> "I spoke with the patient at length today in reference to the psychological aspects of chronic pain problems. * * * I do feel that this patient is having a depressive type reaction and certainly would benefit from anti-depressant therapy for control of sleep disturbance and his chronic pain problems. I have taken the liberty to place him on medications at this time." (Ex. 5f).

Daskalos stated that he would recheck claimant in two weeks "to ascertain his medication status." (Id). However, there is no indication that Daskalos rechecked claimant with regard to his anti-depressant therapy. Instead, on May 29, 1991, Daskalos reported that during the previous two weeks, claimant "had excessive pain complaints and pain behavior and is difficult to motivate." (Ex. 6aa-1). The work hardening program was discontinued, due to claimant's nonparticipation.

On June 24, 1991, Drs. Geist, orthopedic surgeon, and Reimer, neuorologist, examined claimant and opined that he was medically stationary. (Ex. 7). They did not address claimant's depression. Dr. Freeman signed a check-the-box concurrence with the Consultants' report. (Ex. 8). SAIF issued a Notice of Closure on August 16, 1991, listing claimant's medically stationary date as July 30, 1991, the date of Freeman's concurrence. (Ex. 9). The Notice of Closure did not mention claimant's depression.

As we have stated, the compensability of claimant's depression is not disputed. It is not clear whether claimant was treating for that condition when his claim was closed. However, it is clear that the injury-related depressive reaction condition had been diagnosed and treated, with the expectation of improvement, prior to closure. Daskalos' May 1991 opinion that claimant "certainly would benefit from anti-depressant therapy" is uncontroverted. No doctor stated that claimant was psychologically stationary at or prior to claim closure. Under these circumstances, we conclude that the Notice of Closure prematurely closed claimant's claim as it did not consider his psychological condition which was not medically stationary. See Utrera v. Dept. of General Services, 89 Or App 114 (1987); Rogers v. Tri-Met, 75 Or App 470 (1985) (A claimant is not medically stationary if expectations for improvement in his injury-related psychological condition are not considered upon closure of the injury claim).

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 premature closure issue is $600, 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 May 11, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $600, payable by the SAIF Corporation.

In the Matter of the Compensation of
**DEANA L. GABEL, Claimant**
WCB Case No. 91-08598
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral shoulder, elbow and wrist pain. On review, the issue is compensability.

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

We agree with the Referee that Dr. Radecki offered the more persuasive medical evidence regarding claimant's condition, which he diagnosed as fibrositis. Relying on Georgia-Pacific Corp. v. Warren, 103 Or App 275 (1990), rev den 311 Or 60 (1991), claimant asserts that her condition is compensable.

In Warren, the Court of Appeals considered whether the claimant's carpal tunnel syndrome was a compensable occupational disease when the evidence showed that the 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." The court concluded that, because the claimant sought compensation for the syndrome and the syndrome was caused by work activity, the syndrome was compensable Id. at 278.

Here, claimant contends that we should apply Warren and treat her symptoms as the disease for which compensation is sought. Furthermore, claimant asserts that she proved that her work was the major contributing cause of her symptoms.

Assuming without deciding that Warren applies to this case, we conclude that claimant's work was not the major contributing cause of her symptoms. Although Dr. Radecki could not explain why a fibrositis condition becomes symptomatic, (Ex. 7-12), he attributed the development of claimant's condition and symptoms to idiopathic factors, (id. at 10-11), rather than her work, (id. at 51). Therefore, we conclude that claimant's claim is not compensable.

ORDER

The Referee's order dated March 17, 1992 is affirmed.

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In the Matter of the Compensation of
**RENE G. GONZALEZ, Claimant**
WCB Case No. 91-15032
ORDER OF ABATEMENT
James L. Edmunson, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Liberty Northwest Insurance Corporation requests reconsideration of the Board's December 22, 1992 order which affirmed a Referee's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. Contending that the Board has erroneously analyzed this dispute as a "joinder case," Liberty Northwest requests that its denial be reinstated and upheld.

In order to consider this matter further, the Board's December 22, 1992 order is withdrawn. Claimant is granted an opportunity to respond. To be considered, claimant's response must be submitted within 14 days from the date of this order. Thereafter, the Board shall proceed with its reconsideration.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARK A. JOHNSON, Claimant**
WCB Case No. 91-16801
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Schultz's order that: (1) found that claimant was not entitled to temporary partial disability for the period of January 4, 1991 through September 26, 1991; (2) declined to award a penalty for an allegedly unreasonable refusal to pay temporary disability; and (3) affirmed an Order on Reconsideration awarding no unscheduled permanent disability. On review, the issues are temporary disability, penalties, and extent of unscheduled permanent disability.

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

Due to an exacerbation of symptoms, claimant was released from work on December 6, 1990. On December 17, 1990, he was released to modified work and then, on December 27, 1990, to regular work. On January 2, 1991, claimant requested, and received, a leave of absence to enter a drug and alcohol rehabilitation program. He never returned to work.

On October 17, 1991, a Determination Order issued awarding claimant temporary partial disability, "less time worked," for the period of January 4, 1991 through September 26, 1991. The Determination Order was affirmed by an Order on Reconsideration. The insurer paid no temporary disability benefits for the period from January 4, 1991 through September 26, 1991.

Claimant asserts that he is entitled to such benefits based on two arguments. First, he contends that the fact that the Determination Order awarded the temporary partial disability obligated the insurer to pay it. We disagree. Because claimant returned to modified work following his injury and earned his regular at-injury wages, temporary partial disability benefits are not due. See former OAR 436-60-030(2); Mindi M. Miller, 44 Van Natta 2144 (1992). Claimant, therefore, is not entitled to temporary partial disability as a result of the Determination Order since such benefits were calculated at zero.

Claimant also asserts that he was entitled to temporary disability because he proved that he was again released for modified work on January 4, 1991. In support of this assertion, claimant offers a form signed by his treating physician that was not submitted at hearing.

We have no authority to consider evidence not previously considered by the Referee. Under ORS 656.295(5), however, we may remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, we find that claimant failed to show such a compelling reason. In particular, although the document sought to be admitted on review is dated prior to the hearing, there is no explanation for why it was not submitted at hearing. Therefore, we decline to remand to the Referee for admission of the document.

We agree with the Referee's finding that claimant left his job in early January 1991 for reasons unrelated to his injury. Claimant testified that he requested the leave of absence in order to attend the drug and alcohol rehabilitation program, (Tr. 9), and, in late January 1991, voluntarily quit in part because he thought he had secured other employment, (Id. at 19). Although claimant also testified that he felt that he physically could not perform his job during this time, we find that this testimony is outweighed by the fact that claimant was released for full duty. Therefore, we conclude that claimant was not entitled to temporary disability. See Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991); Safeway Stores v. Owsley, 91 Or App 475 (1988). Consequently, claimant is not entitled to a penalty for the insurer's failure to pay the benefits.

ORDER

The Referee's order dated March 6, 1992 is affirmed.

In the Matter of the Compensation of
**SUSAN M. MYERS, Claimant**
WCB Case No. 91-18184
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Thye's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

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

The insurer argues that we should rely on the opinion of Dr. Button, especially his statement that "[c]arpal tunnel syndromes are an exceedingly common condition in life and far more frequent in middle aged individuals, arbitrarily after the age of 40, and also a much higher incidence in females. These are general statistical findings." (Ex. 4-1).

In our view, Button's statement describes claimant's possible predisposition to CTS, rather than the cause of her condition. (See also Ex. 6B-2). Any such predisposition which claimant may have is not relevant to the compensability issue. See Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991); Rodney T. Buckallew, 44 Van Natta 358 (1992). Accordingly, on this evidence, we agree with the Referee's findings and conclusion that the claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 $1,000, 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 May 20, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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In the Matter of the Compensation of
**STEVE L. NELSON, Claimant**
WCB Case No. 90-22627
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requested review of Referee Michael V. Johnson's order that dismissed claimant's hearing request concerning a Determination Order. On review, the issue is the propriety of the Referee's dismissal order.

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

In dismissing claimant's hearing request, the Referee reasoned that the Determination Order was a nullity because the Board had previously upheld the SAIF Corporation's denial of claimant's low back condition. See Steve L. Nelson, 43 Van Natta 1053 (1991). Inasmuch as SAIF was not responsible for the processing of claimant's low back claim, the Referee concluded that the Determination Order which had issued as a result of SAIF's processing was a nullity.

The court has affirmed without opinion the Board's order. Nelson v. Zieman Manufacturing Company, 113 Or App 474 (1992). The Supreme Court has denied review. 314 Or 727 (1992). Consequently, it is the law of the case that SAIF is not responsible for the processing of claimant's low back claim.

Under such circumstances, it follows that the Determination Order was of no effect. Consequently, we agree with the Referee's dismissal of the hearing request.

ORDER

The Referee's order dated June 20, 1991 is affirmed.

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In the Matter of the Compensation of
**WILLIAM H. OLSON, JR., Claimant**
WCB Case No. 91-17330
ORDER ON REVIEW
Jeffrey Foxx, Claimant Attorney
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's injury claim for a single episode seizure (convulsion). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a long-haul truck driver. On July 30, 1991, he drove throughout the night from Medford, Oregon to San Francisco, California, ultimately making a delivery on July 31, 1991. About an hour after making his delivery, he experienced a convulsion.

Claimant was taken to an emergency room where he was diagnosed as having suffered an acute seizure. He was thereafter forbidden to drive. Upon his return to Medford, claimant's family physician, Dr. Southworth, referred him to Dr. Maukonen, a neurologist who specializes in the treatment of epilepsy.

Claimant experienced a loss of consciousness in 1983, but had no further episodes until the July 31, 1991 seizure.

FINDINGS OF ULTIMATE FACT

Claimant's long-haul trucking employment resulted in his being deprived of sleep. This sleep deprivation was the major cause of his July 31, 1991 seizure, which required medical treatment and resulted in disability. The seizure episode was established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denial on the basis that claimant's sleep deprivation did not arise out of and in the course of his employment. The Referee concluded that claimant's failure to sleep between the time he went off duty on July 30, 1991 and the time he delivered his load the next morning took claimant's resultant injury outside the course of his employment activity. We disagree.

Whether a worker's negligence contributed to his/her industrial injury is generally irrelevant in a determination of whether the injury is compensable. See ORS 656.012(2)(a); cf. ORS 656.005(7)(b), which sets forth exceptions that are not relevant to the circumstances of this case. See also 1 Larson, Workmen's Compensation Law, 1-5, §2.10 (1989). Here, SAIF does not dispute that claimant was carrying out the employer's purposes and advancing the employer's interests when he had his seizure. Thus, claimant's seizure occurred during the course of his employment activity. The remaining issue is whether the seizure arose out of that employment activity. We conclude that it did.

Through the employer's testimony, we conclude that sleep deprivation is a risk inherent in long-haul truck driving. Drivers are limited by law to a maximum number of hours behind the wheel within a 24-hour period. They are required to keep daily logs of driving time and hours slept for inspection by state authorities. The purpose of these inspections is to promote safety by reducing or preventing drivers' fatigue and sleep deprivation. (Tr. 97 and 98).

We further conclude from the medical evidence that claimant's seizure episode was caused, in major part, by the sleep deprivation he encountered as a direct result of his work. The treating neurologist, Dr. Maukonen, so opined. Dr. Sullivan, a medical neurologist who also examined claimant, concurred with Maukonen's opinion. Dr. Karasek also opined that claimant's seizure was caused by sleep deprivation, although he further concluded that the major contributing cause of the seizure was claimant's decision not to sleep when he had the opportunity. As noted previously, however, fault is irrelevant in this case, and we disregard Karasek's opinion to the extent that it addresses that issue.

Neither party on review has addressed whether claimant's seizure episode should be characterized as an accidental injury under ORS 656.005(7)(a), or an occupational disease under ORS 656.802(1). Neither has either party discussed whether claimant suffered from a preexisting condition that combined with his seizure episode to prolong his disability or need for treatment. See ORS 656.005(7)(a)(B).

After reviewing the record, however, we conclude that regardless of whether claimant's seizure episode was the result of an injury or a disease, and regardless of whether he suffered from a preexisting condition or "predisposition" to seizures, his July 31, 1991 seizure episode is compensable. As previously noted, the medical evidence is that the major contributing cause of claimant's seizure was the sleep deprivation he encountered as a direct result of his employment. This evidence establishes compensability, regardless of how the claim is characterized.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 3, 1992 is reversed. SAIF's denial is set aside and the claim remanded to SAIF for processing according to law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**LUIS SANCHEZ, Claimant**
WCB Case No. 91-16875
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Menashe's order that upheld the SAIF Corporation's denial of claimant's injury claim for a back strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In September 1991 claimant was employed by SAIF's insured, doing roofing and warehouse work. On the morning of September 4, 1991, claimant slipped on a roof and fell on his back. Although claimant is Spanish-speaking, he managed to communicate that he had fallen to an English-speaking co-worker.

Claimant experienced some pain after the fall, but continued working without difficulty that day and the next two days, Thursday and Friday, September 5 & 6. On Monday, September 9, claimant worked at the employer's warehouse and spent 5 or 6 hours doing heavy lifting. He awoke on September 10, 1991 with a significant pain in his upper back. He reported the problem at work, but did not work that day. On September 12, 1991, claimant sought emergency room treatment. The emergency room physician suspected a back strain and degenerative joint disease. X-rays were negative for fractures, subluxations or significant arthritic changes.

Claimant sought treatment on September 17, 1991 from Dr. Kenney for continuing back pain. Kenney noted objective findings of injury, including muscle spasms and tenderness to palpation.

Dr. Strukel reviewed claimant's medical records and opined that claimant's symptoms were consistent with a lifting or pulling injury.

## ULTIMATE FINDINGS OF FACT

Claimant's September 4, 1991 fall at work and his September 9, 1991 lifting activities were material causes of his subsequent disability and need for treatment for a back strain. The existence of claimant's back strain injury is established by medical evidence supported by objective findings.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim is not compensable, because claimant failed to prove medical causation. We disagree.

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); see Mark N. Weidle, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

The Referee found no reason to disbelieve claimant's account of his September 4, 1991 fall at work and his September 9, 1991 work activities. Neither do we. Accordingly, we conclude, as did the Referee, that the incident and the activities happened as claimant reported them. Consequently, we also agree that legal causation is proven.

In our view, the medical evidence also supports claimant's claim. Dr. Kenney, treating physician, noted claimant's treatment history and his consistent reporting. Kenney opined that either the September 4 fall or the September 9, 1991 lifting activities combined with the fall "could have" caused claimant's subsequent back symptoms. (Ex. 9). Dr. Strukel disagreed with Kenney regarding the injury, stating that claimant's findings are not consistent with a fall onto the back. (Ex. 10-2). However, Strukel had no opportunity to examine claimant and offered no explanation for disagreeing with Kenney regarding the effect of the fall. Under these circumstances, we accord little weight to Strukel's point of disagreement with Kenney. See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983).

On the other hand, Strukel opined that claimant's symptoms "would be more consistent with a muscle strain such as lifting or pulling." (Ex. 10-2). This aspect of Strukel's opinion agrees with Kenney's conclusion that claimant's back symptoms "certainly could have been caused" in part by lifting activities at work. (Ex. 9). In addition, claimant's testimony that he performed 5 or 6 hours of heavy lifting at work the day before his symptoms became acute is uncontroverted. The medical opinion evidence indicates that claimant's back symptoms were consistent with a lifting injury. Furthermore, it is undisputed that claimant had objective findings of an acute back injury when he sought treatment. (See Exs. 2, 4A, 7, 10-2).

Considering this evidence, claimant's consistent reporting, and the absence of off-work contributors, we conclude that claimant has proven that his work exposure was at least a material cause of his disability and need for treatment for a back strain. Accordingly, the claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,500, 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 hearing record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 30, 1992, as republished May 1, 1992, 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 attorney fee of $3,500, payable by SAIF.

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In the Matter of the Compensation of
**RICHARD N. WIGERT, Claimant**
WCB Case No. 91-08452
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Baker's order that: (1) declined to award temporary total disability benefits after December 13, 1990; (2) declined to award penalties and attorney fees for the insurer's allegedly unreasonable failure to close the claim; and (3) declined to award penalties and attorney fees for the insurer's allegedly unreasonable "de facto" denial of a diagnostic test. In its brief, the insurer argues that the Workers' Compensation Department's reclassification of the injury from nondisabling to disabling should be set aside. On review, the issues are temporary total disability, penalties, 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 OPINION

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).

Temporary Total Disability Benefits

We adopt the Referee's reasoning and conclusions regarding the issue of entitlement to temporary total disability benefits.

Penalties and Attorney Fees for Allegedly Unreasonable Resistance to Payment of the Diagnostic Test

The Referee found that the diagnostic test was compensable. The parties do not contest this finding. Concluding that the insurer had a legitimate doubt as to its responsibility for the diagnostic test, the Referee declined to assess a penalty.

The record contains only one report relating to the need for the diagnostic test. (Ex. 19A). In that report, Dr. Jones, M.D., notes that claimant reported that "he has had no previous problems whatsoever with his ankle." This is an inaccurate history, given claimant's severe right leg fracture in the 1950's which resulted in the insertion of a rod in the distal tibia. (Ex. 2). Such circumstances establish that the insurer had a legitimate doubt concerning its responsibility for the diagnostic test. See Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). Accordingly, we agree with the Referee that no penalty is due.

Penalties and Attorney Fees for the Insurer's Unreasonable Refusal to Close the Accepted Claim

Before proceeding to this processing issue, we first address a procedural ruling by the Referee. During the hearing, the insurer argued that it had no duty to close the claim because the claim was properly classified as nondisabling and the May 20, 1991 Department order (reclassifying the claim from a nondisabling to a disabling status) should be set aside. The insurer had not filed a cross-request concerning the Department order. Under such circumstances, the Referee denied the insurer's attempt to first raise this issue during the hearing. (Tr. 6, 9).

Pursuant to OAR 438-06-036, it is the preferred practice to freely allow amendments up to the date of the hearing. However, whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the Referee's discretion. Id; Susan D. Troxell, 42 Van Natta 1300 (1990).

Here, no contention has been made that it was an abuse of discretion for the Referee to refuse to permit the insurer to raise as an issue its objection to the Department classification order. Finding no such abuse, we decline to consider the issue on review.

We turn to the processing issue. Despite finding that the insurer had unreasonably failed to close the accepted portion of the claim, the Referee declined to assess penalties because there were no amounts then due. We agree that the insurer unreasonably failed to close the accepted portion of the claim. However, we find that there is a basis for a penalty.

Penalties may be assessed against an insurer who unreasonably delays or refuses to pay compensation. ORS 656.262(10). Failure to promptly submit a claim for closure after a claimant becomes medically stationary is one form of unreasonable delay or refusal to pay compensation. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984); Georgia-Pacific v. Awmiller, 64 Or App 56, 59-60 (1983).

On February 12, 1990, the insurer accepted claimant's sprain/contusion of the right foot and ankle. (Ex. 6). The insurer issued a current condition denial regarding claimant's osteophyte condition on February 8, 1991. (Ex. 14). The medical evidence addressing the status of the accepted condition reports that claimant was medically stationary in regard to the accepted condition. (Exs. 12-3, 16-5, -6, 20).

On May 20, 1991, the Department issued an order reclassifying the claim as disabling. (Ex. 17). At hearing, the insurer conceded that the Department order obligated it to process the claim as a disabling claim. (Tr. 19). On this basis, we find that it was unreasonable for the insurer not to close the accepted disabling claim. Accordingly, we assess a penalty equal to 25 percent of the compensation due on claim closure. Virgil E. Moon, 42 Van Natta 1003 (1990). Claimant's attorney is awarded one-half of this penalty in lieu of an attorney fee. ORS 656.262(10).

ORDER

The Referee's order dated October 25, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that declined to assess a penalty for failing to submit claimant's accepted claim for closure is reversed. For its unreasonable claim processing, the insurer shall pay claimant a 25 percent penalty based on the compensation due at the time of claim closure. One-half of this penalty shall be paid to claimant's counsel in lieu of an attorney fee. The remainder of the order is affirmed.

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January 21, 1993 Cite as 45 Van Natta 89 (1993)

In the Matter of the Compensation of
**ROBERT K. WILSON, Claimant**
WCB Case No. 91-02533
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Richard C. Pearce, Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant requests review of that portion of Referee Hoguet's order that: (1) declined to grant him permanent total disability benefits; and (2) affirmed an Order on Reconsideration that awarded 44 percent (140.8 degrees) unscheduled permanent disability benefits, in addition to previous awards of 100 percent (150 degrees) scheduled permanent disability for the loss of use or function of the left leg and 20 percent (30 degrees) permanent disability for the loss of use or function of the right leg. On review, the issue is permanent total disability (PTD) or, alternatively, extent of scheduled and unscheduled disability.

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

We find that claimant's noncompensable diabetes mellitus and emphysema (asthma) conditions are contributing factors in his total disability. Dr. Rusch, the attending orthopedic surgeon, reported to claimant's vocational consultant in 1986 that the diabetes is a factor in claimant's employability because diabetics degenerate at a "premature rate." (Ex. 133-3). Later, in 1990, Dr. Rusch opined that claimant's compensable low back, bilateral leg and bilateral shoulder conditions resulted in "significant disability," but that claimant's noncompensable diabetes and asthma "would further complicate and add to the validity of his being permanently and totally disabled." (Ex. 172).

Dr. Hunt, examining orthopedic surgeon, reported that the treatment of claimant's left knee injury, which resulted in an above-knee amputation, was "complicated" by the diabetes. (Ex. 168-1). Dr. Hunt added that the diabetes is "complicating" claimant's compensable left leg, left groin, bilateral shoulder and low back conditions. (Ex. 168-7).

It is undisputed that the diabetes and emphysema arose after and are unrelated to the 1977 compensable injury. Therefore, any disability resulting from those noncompensable conditions may not be considered in determining whether claimant is permanently and totally disabled. See Searles v. Johnston Cement, 101 Or App 589, 592-93, rev den 310 Or 393 (1990).

Claimant has the burden to prove that his disability, excluding disability resulting from the diabetes and emphysema, renders him unable to perform any work at a gainful and suitable occupation. See ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Given the complexity of this medical question, we conclude that its resolution must turn 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).

We are not persuaded that claimant has sustained his burden of proof. The only doctors to issue opinions concerning claimant's disability are Drs. Rusch and Hunt. Neither doctor indicated that claimant is unemployable after excluding consideration of the diabetes and emphysema. (See Exs. 168, 172). Indeed, as we discussed above, their opinions support a contrary finding. Dr. Rusch, in particular, indicated that claimant's disability due to the compensable orthopedic conditions is "significant," then went on to declare claimant PTD only after considering the noncompensable diabetes and emphysema. (Ex. 172).

Dr. Rollins, Ph.D., a vocational rehabilitation consultant, testified that claimant is physically unable to perform any work on a regular and continuous basis. (Tr. 68). However, there is no indication that, in evaluating claimant's physical ability, Dr. Rollins excluded consideration of the diabetes and emphysema. Moreover, Dr. Rollins lacks the medical expertise to discern what portion of claimant's disability is due to the diabetes and emphysema. We discount Dr. Rollins' opinion accordingly. Given the failure of proof, we conclude that claimant is not entitled to PTD benefits.

On the extent of disability issue, we agree with the Referee that there is no basis for any increase in claimant's scheduled and unscheduled permanent disability awards.

ORDER

The Referee's order dated June 24, 1991 is affirmed.

**Board Member Hooton dissenting.**

There is no real question that this claimant is permanently and totally disabled. The question presented in this interesting case is whether claimant's permanent and total disability is compensable as a result of the 1977 injury. To determine that we must exclude any non-compensable disability which did not preexist the injury. Searles v. Johnston Cement, 101 Or App 589, 592-3, rev den 310 Or 393 (1990). There isn't any!

The majority finds that claimant failed in his burden of proof by misinterpreting the evidence presented and by requiring claimant not to prove facts, but to disprove speculation not substantiated by the evidence. In so doing, the majority violates both the purpose and objectives of the Workers' Compensation Law, both in letter and in spirit, as set forth in ORS 656.012.

There is no dispute that claimant has substantial disability in multiple body parts including both scheduled and unscheduled areas. It is also undisptued that claimant suffers from diabetes and emphysema. Nevertheless, claimant is entitled to have this Board consider any disability of which his injury is a material contributing cause. Barrett v. D. & H. Drywall, 300 Or 325 (1985). Claimant is also

entitled to have this Board consider any disability which preexisted the compensable injury. The only thing which we exclude from our consideration in determining whether claimant is entitled to permanent and total disability benefits is disability arising from a noncompensable cause, which did not preexist the injury.

It is important to keep in mind that we exclude only disability arising after the injury and from a noncompensable cause. We do not exclude from consideration, or, for that matter, consider, a condition that does not result in disability.

The majority notes that Dr. Rusch stated that claimant's diabetes and emphysema "would further complicate and add to the validity of his being permanently and totally disabled." (See Ex. 172). As the Referee, whose opinion the majority adopts, indicated that statement is susceptible of more than one interpretation, when viewed outside the context of the record as a whole. Out of context, it could mean that claimant currently suffers disability as a result of those conditions. It could also mean, however, that claimant is permanently and totally disabled as a result of his compensable injury, and that the existence of these conditions simply add to claimant's difficulties. The error made by the Referee and the majority is to require claimant to obtain from Dr. Rusch a clear and unequivocal statement that there is no current disability related to his diabetes and emphysema, despite the fact that there is sufficient evidence presented on the current record on which to conclude which of the two possible explanations the physician intended.

Where there is no evidence upon which to base a conclusion or a reasonable inference, the trier of fact must not speculate. On the other hand, it is equally inexcusable for the trier of fact, whether the Referee at hearing or the Board on review, to decline to find facts simply because one of the parties did not make that task as easy as they might. That is what has happened here.

Each and every element of claimant's disability is compensable as a consequence of his compensable injury. For every identifiable element of disability, whether scheduled or unscheduled, the compensable injury is a material contributing cause. There is no disability experienced by claimant for which his diabetes or emphysema are the sole cause. Consequently, the complication of diabetes and emphysema, on this record, is demonstrated to be complication arising within the context of compensable disability.

Even in the example chosen by the majority to explain its affirmance of the Referee's opinion, the complication of the left knee injury resulting in amputation by claimant's subsequently arising diabetes, the injury remains a material contributing cause of the disability, and it is therefore compensable. Claimant need not exclude some portion of that disability supposedly attributable to claimant's diabetes. He must only show that the injury is a material cause of the disability to be entitled to its consideration in full.

Because the record demonstrates that there is no disability that is directly attributable to claimant's diabetes or emphysema, but rather that these conditions have presented complications to disability already attributable to claimant's compensable injury, there is only one possible interpretation that can be attributed to the statement of Dr. Rusch. That interpretation must be that claimant is totally disabled as a consequence of the injury, and that his emphysema and diabetes represent significant illnesses which eliminate any hope of improvement.

What the majority appears to do is to find that diabetes and emphysema are themselves a form of disability that must be affirmatively excluded by claimant. They are not, and claimant need not. They are in fact merely conditions, or illnesses. While these conditions may be disabling in some individuals, there is no evidence that they are themselves disabling here. Until claimant experiences some disability attributable to these conditions, there is nothing to exclude.

Finally, the majority states that the evidence provided by Dr. Rollins must be discounted because he is not capable of sorting out those elements of disability that are attributable to claimant's emphysema and diabetes. The disability considered by this vocational expert is the disability apparent on this record, all of which is attributable to claimant's compensable injury. Consequently, even if we afford less weight to Dr. Rusch's reports because of some imagined lack of clarity, that cannot provide a basis for ignoring the testimony of the only expert in this record qualified to provide an opinion regarding claimant's employability, a vocational and not a medical question, based on the disability demonstrated in this record.

This Board, for several years, has consistently ignored the findings of vocational experts in support of an award of permanent and total disability, despite the fact that they are the only experts qualified to comment on employability. In those infrequent instances when the Board is willing to rely on vocational evidence in a permanent and total disability claim, that reliance is made to find that claimant is not entitled to the relief requested. This long standing pattern demonstrates that this Board has decided to decline permanent and total disability awards whenever possible, on the merest excuse, regardless of the facts supported by a preponderance of the evidence. The same result occurs here.

The preponderance of the evidence establishes that claimant suffers significant disability as a result of his compensable injury. The uncontradicted vocational evidence requires a finding that claimant's significant disability prevents his employment. Therefore, I would find claimant permanent and totally disabled as a result of his compensable condition.

The findings of the Referee and of the Board on review represent a form of fact finding that violates the spirit and letter or ORS 656.012 which requires that both referees and the Board provide a "fair and just administrative system." Declining to make findings of fact, where that task is possible on the record presented, deprives claimant of the "fair and just" system to which the statutes declares him entitled. Therefore, I dissent.

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January 22, 1993 Cite as 45 Van Natta 92 (1993)

In the Matter of the Compensation of
**MELODY CHILDERS, Claimant**
WCB Case No. 91-16933
ORDER OF DISMISSAL
Schwabe, et al., Defense Attorneys

Claimant, pro se, has requested Board review of Referee Barber's December 7, 1992 order. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

On December 7, 1992, the Referee issued his Opinion and Order. On January 8, 1993, the Board received claimant's request for Board review of the Referee's December 7, 1992 order. The request, which was dated January 1, 1993, was not mailed by certified or registered mail and did not indicate that copies of the request had been provided to the other parties.

On January 12, 1993, the Board mailed a computer generated letter to all 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 all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's December 7, 1992 order was January 6, 1993. Claimant's request, which was dated January 1, 1993, was not mailed by certified or registered mail. Since claimant's request was received by the Board on January 8, 1993, more than 30 days after the Referee's December 7, 1992 order, it is presumed to be untimely until claimant establishes that the mailing was timely. OAR 438-05-046(1)(b). A review of the postage date stamp on the envelope which contained claimant's request confirms that the request was mailed to the Board on January 7, 1993, the 31st day after the Referee's December 7, 1992 order. Thus, claimant will not be able to establish that she mailed her request for review within 30 days of the Referee's December 7, 1992.

Finally, even if claimant could demonstrate that her request for review was timely mailed to the Board, there is no indication in the record that all parties to the proceeding before the Referee were

provided with either a copy, or received actual knowledge of claimant's request for review within the statutory 30-day period. ORS 656.289(3); 656.295(2). Rather, the record suggests that the self-insured employer's first notice of claimant's appeal occurred when it received the Board's January 12, 1993 acknowledgment letter. Consequently, notice of claimant's request to the other party would be untimely and we would still lack authority to review the order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Finally, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. Alfred F. Puglisi, 39 Van Natta 310 (1987).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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January 22, 1993 Cite as 45 Van Natta 93 (1993)

In the Matter of the Compensation of
**DUANE C. GAULT, Claimant**
WCB Case No. 91-01278
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our December 31, 1992 order which reversed a Referee's order that directed the self-insured employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant seeks abatement of our order so that we can retain jurisdiction over this matter to consider the parties' proposed settlement. (Parenthetically, we note that the Supreme Court has denied review of the Court of Appeals' decision in SAIF v. Herron, 114 Or App 64 (1992). 315 Or 271 (1992).)

In light of such circumstances, we withdraw our December 31, 1992 order. Upon receipt of the parties' proposed agreement, we will proceed with our review. The parties are requested to keep us fully apprised of further developments concerning this case.

IT IS SO ORDERED.

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January 22, 1993 Cite as 45 Van Natta 93 (1993)

In the Matter of the Compensation of
**NOEMITH GIRON, Claimant**
WCB Case No. 91-12372
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Schultz & Taylor, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Poland's order that awarded claimant 36 percent (115.2 degrees) unscheduled permanent disability for a thoracolumbar condition whereas an Order on Reconsideration and Determination Order had awarded claimant no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

The parties raise two issues on review. The first issue concerns the validity of the Order on Reconsideration. Although one of the bases for claimant's request for reconsideration of the

Determination Order was a disagreement with the impairment findings used in rating her disability, the Director failed to consider the findings of the medical arbiter prior to issuing his order. Despite the insurer's express waiver of any defects in the Order on Reconsideration, the insurer now contends on Board review that the Order on Reconsideration is invalid since no medical arbiter report was considered by the Department before issuance of the order. The insurer cites our decision in Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992), in support of its contentions.

In Soto, we held that where an objection to a Determination Order or Notice of Closure is based on a disagreement with the findings used in rating claimant's permanent disability at claim closure and no medical arbiter is appointed, the order is voidable. See also Mary A. Dyer, 44 Van Natta 1527 (1992) (Director's Order on Reconsideration invalid where Director issued order prior to receiving and considering medical arbiter report).

However, we recently held that a party who does not object to a Determination Order or Notice of Closure may not use ORS 656.268(7) defensively to have an Order on Reconsideration declared invalid for failure to appoint a medical arbiter, unless the party that objected joins in the motion. Randy M. Mitchell, 44 Van Natta 2304 (1992). In Mitchell, we reasoned that since it is the party who objects to the Determination Order or Notice of Closure who determines the basis for the objection and thereby determines whether or not an arbiter is appointed, only that party has the right to enforce the medical arbiter requirement.

Here, claimant requested reconsideration of the Determination Order and claimant does not join the insurer in arguing that the Order on Reconsideration is invalid. Accordingly, we conclude that the Order on Reconsideration may not be invalidated based on the insurer's objection.

The second preliminary issue is whether a "post-reconsideration order" deposition of the medical arbiter may be admitted into evidence. We agree with the Referee that the deposition cannot be considered. In this regard, we have previously held that medical evidence concerning a worker's impairment generated after the Order on Reconsideration cannot be considered. See Nancy A. Worth, 44 Van Natta 2345 (1992); Teresa L. Erp, 44 Van Natta 1728 (1992); Tor J. East, 44 Van Natta 1654 (1992). Accordingly, we affirm the Referee's evidentiary ruling.

In the alternative, we find that admission of the deposition of the medical arbiter (Dr. Stevens) would not affect our decision to rely upon his findings. Although the deposition indicates that Dr. Stevens had limited recall of the examination and what medical records the Appellate Unit had forwarded to him, his report notes that he had reviewed a medical report performed by Dr. Peterson (independent medical examiner). In addition, we find nothing in the deposition which would cast doubt on the accuracy of the findings Dr. Stevens made during the arbiter examination. Accordingly, admission of the deposition would not alter our conclusions or our reliance on the arbiter's findings.

The Referee deferred to the medical arbiter's report in part based on former OAR 436-35-007(9). Former OAR 436-35-007(9) provided that when the impairment findings of the medical arbiter and the attending physician differ, "the findings of the arbiter shall be used to determine impairment under these rules." Subsequent to the Referee's order, we held that former OAR 436-35-007(9) was inconsistent with the applicable statutes and should be given no effect. Timothy W. Reintzell, 44 Van Natta 1534 (1992). Instead, impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings. Id.

With this modification, we agree with the Referee that the medical arbiter's opinion is the most persuasive opinion regarding claimant's permanent disability. With the exception of a medical arbiter, only the attending physician at the time of claim closure may make findings regarding claimant's impairment for the purpose of evaluating claimant's disability. ORS 656.245(3)(b)(B); Dennis E. Conner, 43 Van Natta 2799 (1991).

Here, prior to claim closure, claimant was examined by Dr. Peterson, an independent medical examiner (IME), at the request of the insurer. The findings of an independent examiner may not be used to assign impairment values under the standards. ORS 656.245(3)(b)(B); Raymond D. Lindley, 44 Van Natta 1217 (1992). Dr. Mata, claimant's attending physician, did not respond to a letter from the insurer inquiring whether or not he concurred with the IME report. The insurer's letter stated that the insurer would assume the attending physician concurred if he did not respond within 14 days. The attending physician did not respond to the letter. However, we do not consider the attending physician's lack of response as an indication that he concurred with the IME report. Rather, we conclude there is simply no evidence from the attending physician concerning claimant's permanent

disability at claim closure. For the reasons stated by the Referee, as well as those expressed above, we have relied on the opinion provided by the medical arbiter.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 is $700, 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 April 28, 1992 is affirmed. For services on review, claimant's attorney is awarded $700, payable by the insurer.

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January 22, 1993 Cite as 45 Van Natta 95 (1993)

In the Matter of the Compensation of
**JOSEPH F. JOHNSTON, Claimant**
WCB Case No. 91-17431
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Sherwood & Coon, Attorneys
Thomas Castle (Saif), Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

Peninsula Radiator Service (Peninsula), a noncomplying employer, requests review of those portions of Referee Podnar's order that: (1) upheld the SAIF Corporation's acceptance, on the noncomplying employer's behalf, of claimant's injury claim; and (2) awarded claimant an $8,000 assessed attorney fee. In its brief, Peninsula also challenges the Referee's evidentiary ruling which excluded hearsay testimony. On review, the issues are compensability, attorney fees and evidence. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

Peninsula objects to the Referee's refusal to admit into evidence the testimony of the employer's son, a former employee, regarding a statement by a third party, not present at hearing, that claimant injured his thumb off work. The Referee sustained a hearsay objection to that testimony. On review, Peninsula contends that the statement is offered not to prove the truth of the matter asserted, but as impeachment evidence.

We review the Referee's evidentiary ruling for abuse of discretion. See ORS 656.283(7); James D. Brusseau II, 43 Van Natta 541 (1991). 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). Nevertheless, 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, the testimony that Peninsula seeks to admit is hearsay, and we agree with the Referee that it was offered to prove the matters asserted. In any event, however the statement is characterized, it would not be entitled to significant weight. Accordingly, we find that the Referee did not abuse his discretion by declining to allow the testimony.

Compensability

We adopt the reasoning and conclusions of the Referee concerning the compensability issue.

Attorney Fees

We adopt the Referee's award of attorney fees.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the Peninsula'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 $750, to be paid by the SAIF Corporation on behalf of Peninsula. 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 31, 1992, as amended May 20, 1992, is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the SAIF Corporation on behalf of Peninsula.

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January 22, 1993 Cite as 45 Van Natta 96 (1993)

In the Matter of the Compensation of
**DENISE M. KUPETZ, Claimant**
WCB Case No. 91-15751
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Claimant requests reconsideration of those portions of our December 24, 1992 Order on Review that: (1) reversed a Referee's penalty based on compensation paid by out-of-state checks; and (2) assessed a $1,500 attorney fee for her attorney's services in obtaining a pre-hearing rescission of the denial of out-of-state medical services, whereas the Referee had awarded $2,250. In addition, claimant seeks clarification of the dollar amount which forms the basis for the penalty awarded for the insurer's unreasonable denial. Specifically, claimant requests that our order reflect that claimant's post-hearing medical services are included in the penalty basis.

Claimant first argues that the insurer's method of reimbursing claimant's expenses was unreasonable, because sight drafts are an impermissible method of payment. See OAR 436-60-160. However, for the reason stated in our Order on Review, we continue to conclude that claimant has not established that the insurer's method of reimbursing claimant's expenses amounted to delay or resistance to the payment of compensation. Consequently, claimant has not established entitlement to a penalty under ORS 656.262(10).

Second, claimant correctly notes that we based our assessment of an attorney fee for counsel's services in obtaining a pre-hearing rescission of the denial on the record, the complexity of the medical services issue, the value of the interest involved and the time devoted to the issue. However, claimant also appears to assert that we failed to consider the value of the result obtained for claimant, the amount of work required of claimant's counsel (due to the timing of the denial's rescission and the complexity of the law) and the contingent nature of claimant's attorney's fees. On the contrary, as we stated in our Order on Review, in assessing the amount of claimant's attorney fee, we considered and applied all the factors set forth in OAR 438-15-010(4), including those highlighted by claimant. Having considered claimant's argument, we continue to conclude that our attorney fee award adequately compensates claimant's counsel for his services in connection with obtaining the pre-hearing rescission of the denial.

Finally, we note claimant's request that we clarify the dollar amount which forms the basis for the penalty awarded for the insurer's unreasonable denial. In our Order on Review, we affirmed the portion of the Referee's order which awarded a penalty of 25 percent of "any unpaid and denied out-of-state medical expenses, including reimbursable ones * * * due to the unreasonable denial of December 26, 1991, one half of which shall be paid to [claimant's attorney] in lieu of any attorney's fee." (See O&O p. 6).

We have held that a penalty for an unreasonable denial may be based on compensation due at the time of hearing, including medical services. Kim S. Jeffries, 44 Van Natta 419 (1992). Here, however, because claimant's post-hearing medical services had not been rendered at the time of hearing, there are no "amounts then due" associated with those services. See Jack O. Pichette, 41 Van Natta 2136 (1989). Consequently, claimant has not established entitlement to a penalty based on her post-hearing medical services.

Accordingly, on reconsideration, as supplemented and amended herein, we adhere to and republish our December 24, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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January 22, 1993 Cite as 45 Van Natta 97 (1993)

In the Matter of the Compensation of
**KEVIN C. O'BRIEN, Claimant**
WCB Case Nos. 91-11524, 90-18071 & 91-09794
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Janice M. Pilkenton, Defense Attorney

Aetna Casualty & Surety Company requests reconsideration of those portions of our December 31, 1992 order which: (1) found that claimant timely requested a hearing from Aetna's August 5, 1991 compensability/responsibility denial of claimant's aggravation claim for a low back condition; and (2) set aside that denial. Contending that claimant raised a "new legal theory" on review (that his request for an expedited hearing also constituted a request for hearing regarding Aetna's August 5, 1991 denial), Aetna argues that claimant should be precluded from asserting this "theory." We disagree with Aetna's characterization of claimant's position as a "new legal theory."

One of the issues raised at hearing, as well as on review, was whether claimant had requested a hearing concerning Aetna's August 5, 1991 compensability/responsibility denial. This issue was raised by Aetna. At hearing, claimant responded that a July 1991 hearing request also represented an appeal of Aetna's subsequent August 5, 1991 denial. On review, claimant contended that his August 15, 1991 request for an expedited hearing (and accompanying affidavit) also constituted a hearing request of Aetna's August 5, 1991 denial.

We do not consider claimant's reliance on another portion of the record in defense of Aetna's "untimely hearing request" argument to represent a "new legal theory." To the contrary, claimant's position has remained constant throughout these proceedings; i.e., he timely requested a hearing from Aetna's August 5, 1991 compensability/responsibility denial. As were all parties, Aetna was fully aware of the documents and correspondence in this record. Thus, we do not share Aetna's concern that it would be fundamentally unfair to permit claimant to refer to another part of that record in support of his position that Aetna's August 5, 1991 denial was properly before the Referee for resolution.

Accordingly, we withdraw our December 31, 1992 order. On reconsideration, as supplemented herein, we republish our December 31, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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January 22, 1993 Cite as 45 Van Natta 97 (1993)

In the Matter of the Compensation of
**JACK O. SLAVEN, Claimant**
WCB Case No. 91-10769
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Black's order that upheld the insurer's denial of claimant's injury claim for a left arm fracture. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a security guard for the employer. In May 1991, he traveled to a location off the work premises to observe a police stop. When the suspect attempted to escape, claimant pursued him, thereby injuring his left arm.

In order to prove the compensability of his claim, claimant must establish that his injury arose "out of and in the course of employment." ORS 656.005(7)(a). He may do so by proving that his injury was "sufficiently" work-related. Rogers v. SAIF, 289 Or 633, 642 (1985).

In Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985), the court discussed seven factors for determining whether an injury is 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; (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 or her own. Whether an injury is work-related is a matter to be decided on a case-by-case basis; not all of the seven factors need be satisfied, and no single factor is dispositive. Preston v. SAIF, 88 Or App 327, 331 (1987); Haugen v. SAIF, 37 Or App 601, 604 (1978).

The Referee applied the factors outlined in Mellis, and concluded that claimant was on a personal mission at the time he was injured. The Referee, therefore, found that claimant's injury was not compensable. We disagree.

Claimant's relationship with the local police predated his injury. Because the employer hoped to obtain greater police protection of the employer's premises, the employer encouraged claimant to assist the police. Although a police radio was available to claimant, he installed a police scanner in his vehicle. On some occasions, while in the course of his employment as a security guard, claimant would act as a "back-up" to the police. His activity generally consisted of standing by in the event the police needed assistance.

On March 23, 1991, two months prior to his injury, claimant responded to a domestic disturbance call he picked up on his scanner. Claimant was performing his duties as a security guard at the time. As a result of his assistance during the incident, claimant received a letter of commendation from the police, in which claimant's active role in assisting the police was noted. Claimant gave a copy of the commendation letter to his supervisor, Bill DeGroot. On the copy, DeGroot congratulated claimant for a job well done. Claimant also received a memorandum of congratulations from the employer's property manager. Finally, the employer's newsletter acknowledged claimant's activities with the police. (Ex. C-2).

From the above evidence, we conclude that claimant's activities with the police during his work shifts were both contemplated by and acquiesced in by the employer. The activities, therefore, became incidental to his employment as a security guard. Further, we find that claimant's activities were not limited to merely staying in the background. The police commendation letter noted that claimant helped in any way he could, and that he not only "observed" but "assisted" in police activities. The employer specifically acknowledged claimant's level of involvement in its letters of congratulations.

With regard to the remaining Mellis factors, we acknowledge that claimant's injury did not occur on the employer's premises. We find, however, that the employer at least indirectly benefitted from claimant's activities with the police because his actions promoted good police relations. Further, the employer paid claimant for the time he spent assisting the police. Finally, we conclude that claimant was not on a "personal mission" at the time of his injury. Rather, he was engaged in activity that benefitted, was known to, and promoted by his employer. Under the Mellis factors, claimant's injury arose out of and occurred in the course of his employment.

Claimant is entitled to an assessed attorney fee for services both at hearing and on review. See 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 these services is $4,000, 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 and claimant's appellate briefs), the complexity of the issue, and the value of the interest to claimant.

ORDER

The Referee's order dated April 3, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by the insurer.

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In the Matter of the Compensation of
**DANNY M. WARD, Claimant**
WCB Case No. 92-01174
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Livesley's order that set aside its partial denial of claimant's current low back condition. On review, the issues are procedural validity of the denial and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Procedural Validity of the Denial

The Referee, relying on Johnson v. Spectra Physics, 303 Or 49 (1987), found that the insurer's "partial denial did not put claimant on notice that insurer was denying his prior back condition, so as to enable him to litigate the compensability of those conditions. Accordingly, it must be viewed as acceptance." The Referee further concluded that claimant's "underlying condition" had not changed and, therefore, the "opinion of insurer's examiner that the underlying pre-existing condition is the cause of claimant's current condition is without legal significance, because the aggravation of the underlying condition was previously accepted."

The insurer disputes these conclusions, arguing that its acceptance of claimant's 1987 industrial injury was limited to a low back strain and, under Georgia-Pacific Corp. v. Piwowar, 305 Or 494 (1988), did not include any of claimant's preexisting conditions. Furthermore, the insurer contends that, under Johnson v. Spectra Physics, supra, its failure to expressly deny the preexisting conditions should not be construed as acceptance of them. We agree with the insurer.

As the Referee found, claimant had a lumbar laminectomy of the L4-5 disc in 1976 and a second lumbar laminectomy in 1979 of the L3-4 disc. In January 1987, claimant sustained an industrial injury. On the 801 form, he indicated that he had a strain in the low back and that this body part had been previously injured. (Ex. 1). The insurer initially deferred the claim. (Id). In June 1987, however, the insurer issued a partial denial of substance abuse while, at the same time, "reaffirm[ing] our acceptance of responsibility for your industrial injury of January 16, 1987, which resulted in a low back strain. Medical expenses and time loss compensations directly related to this accident and condition will continue to be paid." (Ex. 11A). An October 1987 Determination Order awarded 25 percent permanent disability; that award was increased to 30 percent by a stipulated settlement.

In January 1992, the insurer issued another partial denial stating that "[y]ou filed a claim for an industrial injury to your low back allegedly sustained on or about 1/16/87 while you were employed at Pozzi Window Company. That claim was accepted and benefits have been paid according to Oregon Workers' Compensation Law." (Ex. 33-1). The denial further stated that "insufficient evidence exists to justify a contention that your current condition of disk bulge at L5-S1[,] degenerative disc disease, L3-4, canal stenosis and disc herniation is the result of either an injury or disease precipitated by your occupational exposure at Pozzi Window Company." (Id).

Under Georgia-Pacific Corp. v. Piwowar, supra, a carrier's acceptance of a claimant's symptoms includes acceptance of the compensability of the disease causing those symptoms. In this case, we conclude that, based on the insurer's two partial denials, the insurer limited its acceptance to a low back strain. Contrary to claimant's assertions, we find that the insurer's reference to claimant's "condition" encompassed only the low back strain. There is no medical evidence that claimant's low back strain was a symptom of an underlying preexisting condition. Therefore, we conclude that the scope of SAIF's acceptance was limited to a low back strain.

Furthermore, an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted; an insurer's silence regarding other conditions allegedly related to the accepted part of the claim is construed neither as an acceptance nor denial of those conditions. Johnson v. Spectra Physics, supra, 303 Or at 55-56. Here, there is no proof that the insurer either specifically accepted or denied claimant's preexisting conditions and its silence regarding these conditions cannot be construed as bringing those conditions within the scope of its acceptance of claimant's low back strain. Moreover, contrary to claimant's assertions, the insurer's possible payment of compensation for claimant's preexisting conditions, including any permanent disability benefits awarded by the Determination Order and stipulated settlement, does not constitute acceptance of those conditions nor is it an admission of liability. See ORS 656.262(9).

Having found that the insurer's scope of acceptance was limited to a low back strain, we conclude that the insurer's partial denial of claimant's underlying preexisting conditions does not constitute a back-up denial of a previously accepted condition and, therefore, Bauman v. SAIF, 295 Or 788 (1983), is not applicable. Consequently, the partial denial is procedurally valid. We proceed to the merits.

Compensability

In 1977, claimant underwent a lumbar laminectomy as a result of a motor vehicle accident. In 1979, claimant underwent a second lumbar laminectomy after falling over a chair. In 1987, he sustained an industrial injury to his low back. After receiving chiropractic treatment in 1988, claimant did not seek medical treatment for his back until November 1991, when he was examined by Dr. Kitchel, orthopedic surgeon. Claimant underwent an MRI which revealed a disc bulge at L5-S1 associated with a prominent osteophyte on the left, a central disc bulge at L4-5, and mild canal stenosis with a small right paramidline disc herniation at L3-4. (Ex. 25).

The uncontradicted medical evidence shows that claimant's current symptoms result from his underlying conditions and that these conditions preexisted his 1987 industrial injury. (Exs. 30, 32). Thus, in order to prove compensability of his current condition, claimant must show that the industrial injury is the major contributing cause of his current disability and need for treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

The record contains two opinions regarding causation. Dr. Kitchel reported that claimant's "current back problems must relate back to his initial on the job injury and subsequent surgery. I think the on the job injury in January 1987 exacerbated his symptoms but the major contributing cause must be considered to be the original injury and two surgeries." (Ex. 30).

Drs. Baker, orthopedist, and Allen, neurologist, also conducted an independent medical examination (IME). Dr. Baker had conducted a previous IME in 1987 following claimant's industrial injury. Drs. Baker and Allen diagnosed degenerative L3-4, L4-5 and lumbosacral disc disease. (Ex. 32-5). The report further stated that claimant's "present back and left leg complaints are the results of degenerative disc disease and the natural and expected progression of the same, which preceded his work injury of January 16, 1987 on a more probable than not basis. It is therefore, our opinion that his present complaints are probably related to his preexisting back condition including his previous lumbar laminectomies, and the previous degenerative disc disease resulting therefrom." (Id. at 5-6).

These opinions in no way indicate that claimant's 1987 industrial injury is the major contributing cause of his current disability and need for treatment. Instead, they attribute claimant's symptoms to his previous injuries and surgeries. Therefore, we conclude that claimant failed to prove that his current condition is compensable.

ORDER

The Referee's order dated May 8, 1992 is reversed. The insurer's partial denial is reinstated and upheld. The Referee's assessed attorney fee award is reversed.

In the Matter of the Compensation of
**RICHARD L. OVIATT, Claimant**
WCB Case No. 88-21688
ORDER ON REVIEW
Sherwood & Coon, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Myzak's order which: (1) set aside its denial of claimant's aggravation claim for his thoracic spine conditions; (2) awarded temporary disability benefits for the period of July 21, 1988 through February 9, 1990; (3) awarded penalties and attorney fees for an alleged failure to timely deny the aggravation claim; and (4) set aside two Determination Orders as premature. Claimant cross-appeals those portions of the Referee's order which: (1) declined to find his increased low back and right lower extremity pain a part of the accepted compensable claim; and (2) declined to find his degenerative disc disease, current condition and psychiatric conditions compensable. In his brief, claimant asserts that he is entitled to temporary disability benefits regardless of whether he has established that his condition worsened. Claimant also contends that if the Referee's award of penalties and attorney fees for late denial of the aggravation claim is set aside, a penalty and fee should be awarded for the insurer's failure to pay temporary disability benefits. On review, the issues are aggravation, temporary total disability, timeliness of denial, premature closure, compensability, and penalties 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 OPINION

### Scope of Claim Acceptance

We adopt the Referee's "Opinion and Conclusions of Law" on the issue of scope of claim acceptance.

### Perfection of Aggravation Claim

The insurer contends that claimant did not perfect an aggravation claim. We disagree.

A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3). Here, on July 11, 1988, claimant reported to his treating physician, Dr. Struckman, orthopedic surgeon, that his pain was "terrible," and he "had to leave his job because he physically cannot do it." (Ex. 86-2). Dr. Struckman noted that claimant complained of leg and neck pain with "radicular phenomenon in his arms and may well also have a cervical disc." (Id). On July 13, 1988, Dr. Struckman reported claimant's leg pain, "degenerative change in his upper back," and possible nerve entrapment in his lower back. (Id). Dr. Struckman recommended: "He will simply rest for a month. He is not to work in that period of time." (Id).

The insurer concedes that claimant sustained increased cervical, lower and upper back pain in July 1988. However, it argues that for claimant to perfect an aggravation claim, there had to be notice of a worsening of the dorsal thoracic spine injury which was accepted by the employer/insurer.

Dr. Struckman's chart note expressly referenced claimant's claim with the insurer and requested that it be reopened. In his immediately prior chart note of May 16, 1988, he expressly noted that claimant's mid dorsal spine pain was progressively worsening following his return to work. Therefore, we conclude that, in light of his May 1988 chart note, Dr. Struckman's July 1988 chart note, which reported claimant's increase in pain in the upper back and resulted in claimant being taken off work, is sufficient to perfect an aggravation claim for claimant's accepted dorsal spine injury.

### Aggravation

The Referee found that claimant had established a compensable aggravation of his thoracic spine condition. We disagree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of his thoracic spine condition, claimant must show that increased symptoms or a worsened underlying condition caused him to be less able to work, thus resulting in a 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 worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). If the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8).

Claimant's thoracic spine injury claim was closed by Determination Order on June 21, 1988. Claimant was awarded 30 percent unscheduled permanent disability. As a result of increased midback pain, claimant presented to Dr. Struckman on July 11, 1988. The doctor noted diffuse tenderness and pain, and prescribed rest for one month. Thus, we find that claimant has established a symptomatic worsening of his compensable thoracic spine condition, supported by objective findings.

However, claimant must also establish that the worsening resulted in a diminished earning capacity. Here, in May 1988, before the June 1988 Determination Order, Dr. Struckman reported that claimant had returned to modified work, was not handling it very well, and that claimant "should be declared unable to work." (Ex. 86-2). In June 1988, Dr. Struckman noted:

> "I certainly would agree to having [claimant's] job modified so that he might be able to do it. I would just doubt whether that is going to be possible but would certainly like to try it if it is."

Subsequently, claimant was unable to successfully perform the modified job, as previously recognized by Dr. Struckman. Therefore, the record does not sustain the conclusion that, as a result of a worsening of his compensable dorsal condition, claimant's earning capacity was diminished below the level fixed at the time of the last arrangement of compensation.

Thus, we conclude that claimant's thoracic spine condition has not resulted in a diminished earning capacity; accordingly, he has failed to establish a compensable aggravation. See Smith v. SAIF, supra.

In addition, even if claimant had established a diminished earning capacity, we are not persuaded that such reduced capacity was more than a waxing of symptoms contemplated by the prior award. Dr. Bailey expressly anticipated future waxing and waning. (Ex. 92). Prior to the initial closure of his claim, claimant was off work for almost a year until he returned to the modified position shortly before claim closure. Dr. Struckman, as discussed above, did not think claimant was able to work although he released him to attempt the modified work. Under the circumstances, we find that claimant has failed to establish that his worsened symptoms exceeded what was contemplated at the time of the June 1988 Determination Order.

We therefore reverse the Referee on the issue of aggravation. The Referee's attorney fee award of $1,250, awarded in conjunction with the aggravation issue, is also reversed.

Penalties and Attorney Fees for an Alleged Late Denial of Aggravation

We adopt the Referee's "Opinion and Conclusions of Law" on the issue of penalties and attorney fees for an untimely denial of the aggravation claim.

Premature closure

We have above found that the original scope of acceptance should have included the thoracic spine. However, we have also concluded that claimant did not sustain an aggravation of that condition in July 1988. Therefore, claimant's claim was properly closed by the May 19, 1989 and August 9, 1990 Determination Orders. Therefore, we reinstate the May 19, 1989 and August 9, 1990 Determination Orders.

Temporary Disability Benefits

We adopt the Referee's "Opinion and Conclusions of Law" on the issue of entitlement to temporary disability benefits or "interim compensation."

Compensability of Claimant's Degenerative Disc Disease, Current Condition and Psychological Condition

We adopt the Referee's "Opinion and Conclusions of Law" on the issue of compensability of claimant's degenerative disc disease, current condition and psychological condition, with the following supplementation.

On review, claimant contends that, in determining compensability, the Referee should have applied the law in effect prior to July 1, 1990. We disagree.

In Eler M. Cousin, 44 Van Natta 2285 (1992), we concluded that the date of a request for hearing on a specific issue and the date on which a hearing is convened on that same issue are the relevant dates for establishing whether the law prior or subsequent to the 1990 amendments should be applied. Here, although a hearing was convened on June 25, 1989 and continued on April 3, 1991, the June 25, 1989 hearing was obviously not convened for purposes of litigating the insurer's denial of claimant's degenerative disc condition, current condition and psychological condition, as that denial was not issued until December 3, 1990.

Accordingly, although claimant's supplemental hearing request, filed December 11, 1990, may have contained some of the same issues previously raised by the first hearing request, the Referee properly applied the "new law" to the issues raised by the December 3, 1990 denial and the subsequent December 11, 1990 request for hearing.

Claimant has prevailed against the insurer's request for review on the issue of temporary disability benefits. We conclude that, for services on review concerning the issue of temporary disability benefits, claimant is entitled to an attorney fee of $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant'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 services rendered 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 May 8, 1991, as amended by the May 13, 1991 order, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's February 9, 1990 aggravation denial is reversed. The Referee's attorney fee award of $1,250 is also reversed. The insurer's denial is reinstated and upheld. That portion of the Referee's order that set aside the May 19, 1989 and August 9, 1990 Determination Orders is also reversed. The Determination Orders are reinstated. The remainder of the Referee's order is affirmed. For services on Board review concerning the issue of temporary disability benefits, claimant's attorney is awarded an attorney fee of $500, to be paid by the insurer.

In the Matter of the Compensation of
**ERIC P. BERLIN, Claimant**
WCB Case No. 91-14123
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of claimant's occupational disease claim for hearing loss. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation.

In 1989, claimant worked at Valley Printing Service for two or three months. On occasion, he wore a personal stereo headphone set while running a folder machine. The music from the stereo could be heard over the noise of the folder machine.

While working at Platt Lithograph, claimant listened to a small radio from which music could be heard over the sound of the printing machines.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to prove that employment conditions were the major contributing cause of his hearing loss. Claimant asserts that the Referee erroneously limited his analysis of compensability to employment conditions involving Platt Lithograph whereas claimant was asserting that his entire employment in the printing business caused his hearing loss. Claimant contends, therefore, that the Referee should have applied the "last injurious exposure" rule and that, under this rule, claimant was required to prove only that employment conditions "could have" caused his hearing loss. Asserting that he carried this burden, claimant maintains that he proved the compensability of his claim.

The last injurious exposure "could have" rule is applied to assign responsibility for a compensable occupational disease between successive employers. See Bracke v. Baza'r, 293 Or 239, 248 (1982). However, when compensability is contested, the claimant must first prove that the occupational disease is compensable before an analysis of responsibility begins. Id. Specifically, the claimant must show that employment conditions were the major contributing cause of the condition. See ORS 656.802(2). Here, the insurer clearly challenged compensability. Therefore, although claimant is not limited to proof involving his employment conditions at Platt Lithograph, he must nevertheless satisfy ORS 656.802(2).

The record contains three opinions regarding the cause of claimant's hearing loss. The first is that of Dr. Epley, an neuro-otologist with whom claimant initially sought treatment after experiencing tinnitus. Epley initially reported that claimant had hearing loss "typical of noise induced loss" and that claimant was "developing hearing loss from his present working environment." (Ex. 4B-1). Epley, therefore, opined that based on a reasonable medical probability, claimant's hearing loss was related to his work. (Id. at 2).

Dr. Epley later altered his opinion by concurring with a letter written by the insurer's attorney, which stated that if the employer were in compliance with OSHA noise standards, the employment at Platt Lithograph was not the major contributing cause of claimant's hearing loss. Epley also agreed that it was possible that claimant's hearing loss resulted from his listening to loud music on his car stereo. (Id. at 2).

Dr. Epley subsequently concurred with a letter written by claimant's attorney stating that Epley was not convinced that the employer was actually in compliance with OSHA noise standards. Epley, therefore, agreed that it was possible that the exposure at Platt Lithograph could have caused at least

some of claimant's hearing loss. Epley further agreed, however, that it was not possible to determine the degree to which claimant's work, as opposed to non-work causes, contributed to his loss. (Ex. 11-1).

Claimant also was examined by Dr. Hodgson, otolaryngologist, for an independent medical examination. Like Epley, Hodgson indicated that he could not determine with probability the cause of claimant's hearing loss, (Exs. 8-1, 13-5), finding that claimant's employment at Platt Lithograph, his prior employment, or non-work related noise exposure could have caused the loss. (Ex. 13-5).

Finally, claimant was examined by Dr. Schroeder, an ENT specialist, who reported that claimant's loss was likely secondary to "on-the-job noise exposure." (Ex. 9A-2).

We first find that although Dr. Epley was claimant's initial treating physician, his opinion is not entitled to particular deference. He saw claimant on only two occasions and, thus, he essentially had no greater opportunity to observe claimant's condition than did Drs. Hodgson or Schroeder. See Weiland v. SAIF, 64 Or App 810 (1983). Further, because Epley's opinion was changeable, depending on which party contacted him, the persuasiveness of his opinion is diminished.

We also find Dr. Schroeder's opinion to be entitled to little weight. His conclusion regarding causation is conclusory, and it relies on claimant's statement that he did not listen to loud music. That statement is contrary to the remaining evidence. See Somers v. SAIF, 77 Or App 259, 263 (1986).

As previously noted, it is claimant's burden to prove that his work exposure was the major contributing cause of his hearing loss. He has failed to do so. Dr. Epley's opinion does not provide the requisite medical opinion, for it fails to indicate that claimant's employment was the major cause of his hearing loss. Although Epley once indicated that claimant's loss was "work-related," he also noted the other potential contributors to that loss. Further, Epley's opinion was partially based on his understanding that Platt was not in compliance with OSHA standards. The record, however, is to the contrary.

ORDER

The Referee's order dated March 5, 1992 is affirmed.

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January 26, 1993 Cite as 45 Van Natta 105 (1993)

In the Matter of the Compensation of
**LIANA L. DODERER, Claimant**
WCB Case No. 91-12683
ORDER ON REVIEW
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Black's order that affirmed an Order on Reconsideration awarding 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of claimant's left hand and 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of claimant's right hand. Claimant also seeks to have the Board consider documents that were not admitted at hearing, which we construe as a motion to remand for admission of additional evidence. On review, the issues are remand and extent of scheduled permanent disability. We decline to grant the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Along with her brief, claimant submitted a handwritten statement, medical records from her treating occupational therapist, and a medical information form filled out by her treating physician, Dr.

Vranna, for the Employment Division of the State of Oregon. Claimant asserts that she had intended to read her statement at the hearing but her attorney advised her not to do so. Furthermore, she contends that her attorney neglected to obtain the medical records from the occupational therapist despite her own opinion that the records were "crucial" evidence. Claimant argues that, because she was not allowed to read her statement and the medical records were not considered by the Referee, she was denied a fair hearing. She wishes the Board to consider the documents on review.

We have no authority to consider evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, claimant essentially asserts that she proved a "compelling reason" based on her belief that her attorney should have allowed her to read her statement at hearing and obtained and submitted her occupational therapist's records. Whatever the merits of claimant's belief, her arguments are not sufficient to merit remand. All of the documents submitted by claimant on review were obtainable at the time of hearing. Therefore, we deny the motion to remand and do not consider any evidence beyond that already included in the record.

Extent of Scheduled Permanent Disability

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), "only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1991). Furthermore, impairment findings made by another medical provider at the time of claim closure may be used to determine impairment only if the attending physician concurs with the findings. Former OAR 436-35-007(8) (WCD Admin. Order 2-1991); Kathy Bott, 44 Van Natta 2366 (1992).

In this case, the record contains a February 4, 1991 closing examination from claimant's treating physician, Dr. Vranna, a January 2, 1991 Physical Capacity Evaluation (PCE), and a May 28, 1991 report from Dr. Ochoa. There is no evidence that Dr. Vranna concurred in the findings of Dr. Ochoa. Furthermore, although Dr. Vranna referred to the PCE in his closing examination report, it was only in reference to the job restrictions contained in that report. There is no indication that Dr. Vranna adopted the impairment findings in the PCE. Therefore, we do not consider Dr. Ochoa's report or the PCE in determining claimant's permanent impairment.

Relying only on Dr. Vranna's closing examination report, we agree with the Referee that there was no evidence of loss of strength in claimant's wrists. (Ex. 21-1). Former OAR 436-35-007(14)(a) (WCD Admin. Order 2-1991). Furthermore, claimant did not prove any loss of flexion in her wrist joints, (Ex. 21-1) former OAR 436-35-080, or loss of sensation in either hand, (Ex. 21-1) former OAR 436-35-110. Therefore, we agree that she is entitled only to the 5 percent awarded by the Determination Order and affirmed by the Order on Reconsideration.

ORDER

The Referee's order dated March 20, 1992 is affirmed.

In the Matter of the Compensation of
**GLENN L. GATLIFF, Claimant**
WCB Case No. 90-13961
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Nichols' order that: (1) found that claimant's back injury claim was not prematurely closed; (2) did not address claimant's contention that the insurer's "de facto" denial of his psychological condition should be set aside; and (3) affirmed the June 28, 1990 Determination Order which awarded no additional permanent disability benefits. On review, the issues are premature closure, compensability, and extent of scheduled and unscheduled 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

### Premature Closure

We adopt the Referee's reasoning and conclusions regarding the issue of premature closure with the following supplementation.

At the time of June 28, 1990 Determination order, Dr. Strum, M.D., was claimant's treating physician for his compensable knee condition, and Dr. Tiley, M.D., was his treating physician for his compensable low back condition. Drs. Strum and Tiley last treated claimant on November 22, 1989 and December 29, 1989 respectively. (Ex. 76-6). In May 1990, both physicians found claimant medically stationary, opined there was no permanent impairment regarding the work injury, and released him for regular work. (Exs. 80, 81). We find the opinions of claimant's treating physicians persuasive evidence that claimant was medically stationary at the time of claim closure.

Claimant argues that we should not rely on the opinions of his treating physicians because they last examined him several months before they gave their opinions regarding his medically stationary status. We disagree. At the time the physicians last examined claimant, they both noted that they planned to see claimant only on an as needed basis. (Ex. 76-6). Furthermore, between the time claimant last saw these physicians and the time they declared him medically stationary, he did not seek medical treatment. In addition, Dr. Tiley opined that claimant had no understanding that his level of symptomatology was minimal. (Ex. 76-6).

Claimant also argues that the opinions of Drs. Strum and Tiley are unpersuasive because they did not consider claimant's psychiatric condition when they determined that he was medically stationary. However, we find no persuasive evidence that claimant had a psychiatric condition at claim closure. Claimant did not seek psychiatric treatment prior to claim closure. Instead, he relies on the May 21, 1990 report of Dr. Friedman, examining psychiatrist with the Western Medical Consultants, to establish that he had a psychiatric condition before claim closure. However, we do not find Dr. Friedman's report persuasive.

Dr. Friedman offered several comments stating that it was difficult to make a diagnosis regarding a psychiatric disorder because claimant appeared to be consciously presenting himself as more impaired than he really was. (Ex. 82-3). On the other hand, she listed a diagnosis of "[a]djustment disorder with mixed emotional features" and "[p]sychological factors contributing to a physical condition." (Ex. 82-4). We find this diagnosis inconsistent with her numerous statements about her uncertainty as to whether claimant had a psychiatric condition. Because of these inconsistencies, we do not find Dr. Friedman's opinion persuasive and, accordingly, give it little weight. See David H. Olson Jr., 42 Van Natta 1336 (1990). Consequently, we are not persuaded that claimant had a psychiatric condition, let alone at the time of claim closure.

Dr. Friedman also opined that claimant would benefit from seeing a mental health professional specializing in helping people deal with chronic pain. (Ex. 82-3). Claimant argues that this recommendation establishes that he was not medically stationary at claim closure. However, given the uncertainty and inconsistencies in Dr. Friedman's report, we do not find it persuasive evidence that claimant needed additional medical treatment at claim closure.

Claimant also argues that, on December 29, 1989, Dr. Tiley recommended that claimant initiate an exercise program mediated by physical therapy, thus indicating, claimant argues, the need for further medical treatment. Claimant is mistaken. Although Dr. Tiley encouraged claimant to be on a regular exercise program, he explicitly stated that it did not have to be mediated by physical therapy. (Ex. 76-6). Instead, Dr. Tiley stated that he would prefer that claimant do the exercises on his own and be responsible for himself. Id.

Finally, claimant argues that, instead of relying on the opinions of his treating physicians at claim closure, we should rely on the following to determine that his claim was prematurely closed: (1) a June 13, 1990 visit to the emergency room where claimant sought treatment for back pain; and (2) an August 20, 1990 opinion from Dr. Donald Smith, a subsequent treating physician. We do not find this argument persuasive.

During the June 13, 1990 visit to the emergency room for back pain, claimant related that he had a disc bulge and was diagnosed with an "acute exacerbation of lumbar disc disease." (Ex. 84-2). However, both Dr. William Smith, consulting physician, and Dr. Donald Smith opined that the L4-5 disc bulge was not related to the work injury. (Exs. 86-1, 90). There is no evidence to the contrary.

On August 20, 1990, Dr. Donald Smith opined that claimant was not medically stationary in that: (1) claimant had not had a satisfactory diagnosis; and (2) Dr. Smith concurred with claimant's opinion that he was disabled by psychiatric problems and recommended a psychiatric interview and possible treatment. (Ex. 85A-1). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. I.R. Simplot & Co., 84 Or App 622, 625 (1987). Here, in addition to applying an incorrect test to determine whether claimant was medically stationary, Dr. Smith's opinion does not relate to claimant's condition at claim closure. ORS 656.005(17). Therefore, his opinion is not persuasive evidence that claimant was not medically stationary at claim closure.

Compensability of Psychological Condition

The Referee found that she had no jurisdiction to consider claimant's aggravation claim which was comprised of allegations that his physical condition had worsened and he had developed a psychological component to the accepted claim. Reasoning that claimant's aggravation rights expired on January 26, 1990, and the aggravation claim was made after that date, she found that jurisdiction over such an "aggravation" claim was with the Board in its own motion capacity. We adopt the Referee's reasoning and conclusions regarding her lack of jurisdiction over any aggravation claim in this case involving either physical or psychological components.

However, claimant also raised the issue of a "de facto" denial of a psychological condition. (Tr. 3). The Referee did not address this issue. Although the Referee did not have jurisdiction to address an aggravation claim, the compensability of claimant's psychiatric condition is within the jurisdiction of the Hearings Division.

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, although the Referee did not address the compensability of the psychiatric condition, we find that the record is fully developed in regard to that issue. Thus, remand is not necessary.

Claimant is asserting the compensability of a psychological condition (somatoform pain disorder) as a consequence of his compensable low back injury. Because claimant alleges the compensability as a "consequence" of a condition previously deemed compensable, the somatoform pain disorder 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); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

The issue of whether claimant's compensable injury is 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).

The medical record contains two opinions regarding diagnosis and causation of a psychiatric condition. Both opinions are the result of one-time psychiatric examinations. Therefore, neither has the advantage of any treatment history with claimant.

Dr. Kuttner, psychiatrist, performed a psychiatric examination in October 1991. (Ex. 103). He opined that, although claimant's preexisting personality factors set the stage for development of the somatoform pain disorder, the compensable injury was the major contributing cause of the psychiatric condition. (Ex. 103-6, -7). We find Dr. Kuttner's opinion conclusory. Although acknowledging preexisting personality factors, he does not explain their effect on claimant's psychiatric condition. Instead, he simply states that the work injury is the major cause of the psychiatric condition.

Dr. Bellville, psychiatrist, examined claimant in December 1991 and agreed that claimant suffered from a somatoform pain disorder. (Ex. 105). However, he opined that the work injury was not the major contributing cause, even though it may have become the focus for claimant's concerns. (Ex. 105-6). Instead, Dr. Bellville persuasively explained that preexisting personality factors were the major cause of the psychiatric condition. We rely on Dr. Bellville's opinion because we find it well-reasoned. Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we find that claimant has failed to prove that the work injury was the major contributing cause of his somatoform pain disorder.

Extent of Permanent Disability

The Referee found that claimant was not entitled to any additional permanent disability beyond that previously awarded by stipulation because claimant did not establish any measurable impairment, either scheduled or unscheduled, due to the work injury. We adopt the Referee's reasoning and conclusions on this issue.

ORDER

The Referee's order dated January 17, 1992 is affirmed in part and modified in part. The self-insured employer's "de facto" denial of claimant's somatoform pain disorder is upheld. The remainder of the Referee's order is affirmed.

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January 26, 1993 Cite as 45 Van Natta 109 (1993)

In the Matter of the Compensation of
**RANDEL G. JENSEN, Claimant**
WCB Case No. 92-02227
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lane, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Mills' order that found claimant was entitled to interim compensation. On review, the issue is interim compensation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception.

The Referee found that claimant was suspended from his job on September 16, 1991 for a period of 30 days. We find instead that claimant was terminated from his job on September 16, 1991 and was offered reinstatement after 30 days. (Tr. 100, 101).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to interim compensation from November 27, 1991 through February 11, 1992, the date of the employer's denial. We disagree.

"Interim compensation" is temporary disability payments made between the carrier's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). Although a claimant is entitled to interim compensation whether or not his or her claim is ultimately found compensable, there is no duty to pay such compensation if the worker has not left work pursuant to ORS 656.210(3). Bono, supra at 408, 410. Moreover, a claimant who leaves work for reasons unrelated to the injury is not entitled to interim compensation. Nix v. SAIF, 80 Or App 656.659 (1986).

Here, claimant was terminated from his employment on September 16, 1991 because he had tested positive on a drug test. The employer offered to reinstate claimant after 30 days if he could supply a drug test that was not positive at that time. Claimant did not ask to be reinstated. Claimant sought medical treatment and was released from work on November 26, 1991, more than a month after he was terminated.

Claimant did not leave work because of his compensable condition. Rather, claimant left work because he was terminated for testing positive on a drug test. Therefore, we conclude that claimant left work for reasons unrelated to his injury. Because he did not "leave work" as that phrase is used in ORS 656.210(3), he is not entitled to interim compensation benefits. See Weyerhaeuser Co. v. Bergstrom, 77 Or App 425 (1986); Faustino Martinez, 44 Van Natta 2585 (1992). Accordingly, we reverse the Referee's award of interim compensation.

ORDER

The Referee's order dated July 1, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that awarded claimant interim compensation is reversed. The remainder of the order is affirmed.

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January 26, 1993 Cite as 45 Van Natta 110 (1993)

In the Matter of the Compensation of
**KEITH D. MILLER, Claimant**
WCB Case No. 89-10246
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of that portion of Referee McWilliams' order which: (1) set aside an Order on Reconsideration as invalid; and (2) found that jurisdiction over a Notice of Closure remained with the Director. In its respondent's brief, the self-insured employer objects to the Referee's award of an attorney fee payable from any increased compensation resulting from a future validly issued reconsideration order. On review, the issues are jurisdiction and attorney fees.

We affirm and adopt that portion of the Referee's order which held that the Order on Reconsideration was invalid because it issued without the Director's consideration of a medical arbiter's report despite claimant's objection to his impairment findings. See Olga I. Soto, 44 Van Natta 697 (1992), recon den 44 Van Natta 1609 (1992).[1]

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[1] Here, an arbiter's report was completed subsequent to the issuance of the Order on Reconsideration. As amended in 1991, ORS 656.268(6)(a) allows consideration of such a report at hearing even if not prepared in time for use in the reconsideration proceeding. However, because claimant's request for reconsideration was made prior to October 1, 1991, amended ORS 656.268(6)(a) does not apply.

We reverse that portion of the Referee's order which awarded an "out-of-compensation" attorney fee payable from any increased compensation resulting from the Referee's decision to vacate the reconsideration order. Inasmuch as jurisdiction over this matter has never left the Director, it follows that the Referee was without authority to grant a prospective attorney fee award. Rather, any such future attorney fee award would be within the authority of the Director once a valid Order on Reconsideration is issued. See ORS 656.268(6)(a); OAR 436-30-050(14).

ORDER

The Referee's order dated July 10, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which awarded an "out-of-compensation" attorney fee is reversed. The remainder of the Referee's order is affirmed.

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January 26, 1993 Cite as 45 Van Natta 111 (1993)

In the Matter of the Compensation of
**RONALD P. OLSON, Claimant**
Own Motion No. 92-0582M
OWN MOTION ORDER
Popick & Merkel, Claimant Attorneys
Williams, et al., Defense Attorneys

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on October 16, 1986. The employer opposes the authorization of temporary disability compensation on the ground that claimant has withdrawn from 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, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is making reasonable efforts to obtain work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant submitted tax records showing earnings in 1990. Thus, there is no question that claimant was in the work force in 1990. However, the question is whether claimant was in the work force in May 1992 when his condition worsened requiring surgery. Claimant stated that, although he has not had employment since 1990, he is "on call" on a list of substitute janitors for a school district and is also on a work list for a temporary service company. We do not find that placing his name on two job lists since 1990 constitutes a reasonable job search effort on claimant's part.

Claimant also contends that the compensable injuries to his knee and low back have worsened making any effort to work or find work futile. However, claimant submits no evidence to support this contention. He refers us to a copy of a May 16, 1991 letter from Dr. Hayes, M.D. However, although Dr. Hayes recommends knee surgery, he does not address claimant's ability to work prior to the need for knee surgery.

In a July 22, 1988 report, Dr. Gripekoven, examining orthopedist, opined that claimant could be employed on a full time basis. According to a March 28, 1989 Opinion and Order, Dr. Powers, treating chiropractor, concurred with Dr. Gripekoven's report on October 4, 1988. This is the most current evidence submitted by the parties regarding claimant's ability to work. Claimant submitted no evidence

establishing that, because of his compensable knee and low back injuries, it would be futile for him to work or make reasonable efforts to find work.

Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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January 26, 1993 Cite as 45 Van Natta 112 (1993)

In the Matter of the Compensation of
**RAY PERYMAN, Claimant**
Own Motion No. 92-0681M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on November 15, 1990. SAIF opposes the authorization of temporary disability compensation on the ground that claimant has withdrawn from 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, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant has submitted an affidavit wherein he states that he worked until August 1991 at which time he was unable to continue working because of pain. On February 11, 1992, claimant wrote to a claims adjustor advising that he was unable to sit, stand, walk or lay down for any length of time and requesting medical services. On July 24, 1992, Dr. Goldthwaite opined that claimant suffered extreme disability due to his worsening condition and required surgery. We have no evidence in our file that SAIF ever responded to claimant's request until after they received a request for own motion relief from claimant's attorney dated September 1, 1992.

Inasmuch as claimant has sumitted evidence that he was willing to work but not able to work because the compensable injury has made such efforts futile, we conclude that he was making reasonable efforts to seek work and therefore remained in the work force.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning November 23, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Finally, 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. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
**CLARENCE R. PEYTON, Claimant**
Own Motion No. 91-0562M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 7, 1993 Own Motion Order Reviewing Carrier Closure that affirmed the SAIF Corporation's April 30, 1992 Notice of Closure. We based our decision on the fact that claimant's request for review was untimely in that it was not filed until 91 days after SAIF's Notice of Closure.

Claimant contends that he had good cause for his untimely request for review because he relied on his attorney who failed to timely request review. Claimant notes that his attorney was disciplined by the Bar for his mishandling of other clients' legal matters.

A request for review of a carrier closure must be filed not later than the 60th day after the mailing date of the Notice of Closure. OAR 438-12-060(1). A request that is filed after 60 days, but within 180 days of a Notice of Closure, confers jurisdiction if claimant has good cause for the late filing. Id.

Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). While the neglect of an attorney's employee who is not responsible for handling hearing requests may be excusable neglect, see Brown, supra at 460, neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. See Sekermestrovich v. SAIF, 280 Or 723, 727 (1977); EBI Companies v. Lorence, 72 Or App 75, 78 (1985); Pedro Mendoza, 44 Van Natta 247 (1992). We find that the same analysis applies to requests for review of carriers' closures.

Here, there is no evidence as to whose neglect in claimant's attorney's office caused the untimely filing. Therefore, we cannot determine if the untimely request was caused by the excusable neglect of an employee who was not responsible for handling requests or the inexcusable neglect of the attorney. Accordingly, we conclude that claimant failed to establish good cause.

In any event, claimant seems to be requesting benefits that we are without authority to grant. In a letter received by the Board on October 23, 1992, claimant appears to request additional permanent disability compensation. Because claimant's aggravation rights have expired, his claim is in own motion status. That means that, although he is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future monetary compensation is restricted to time loss benefits under limited circumstances. ORS 656.278(1)(a). Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our own motion capacity. Independent Paper Stock v. Wincer, 100 Or App 625 (1990).

Accordingly, as supplemented herein, we adhere to and republish our January 7, 1993 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
**GENE A. REDWINE, Claimant**
WCB Case No. 91-14945
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Howell's order that affirmed an Order on Reconsideration which awarded no scheduled permanent disability for claimant's bilateral hand and wrist dermatitis condition. In its brief, the insurer argues that the Referee erred in finding that it had accepted liability for an occupational disease rather than a temporary flare up of a preexisting condition. On review, the issues are scope of acceptance and extent of scheduled permanent disability.

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

Scope of Acceptance

The Referee found that the insurer accepted liability for an occupational disease - the worsening of claimant's preexisting dermatitis condition. He also found that the acceptance did not mean that the insurer was liable for the preexisting permanent disability.

The issue of the scope of the insurer's January 10, 1991 acceptance was decided at an earlier hearing. On May 3, 1991, Referee Holtan issued an order which found that the insurer stipulated at hearing to accept the occupational disease of bilateral wrist and hand contact dermatitis. (Ex. 12A). This previous order was not appealed and has become final by operation of law. At the present hearing, the insurer argued that its January 10, 1991 acceptance was limited to a temporary flare up of claimant's preexisting dermatitis condition. We find that this argument is barred by issue preclusion.

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. North Clackamas School District v. White, 305 Or 48, on recon 305 Or 468 (1988); Jimmy M. Campoz, 42 Van Natta 903 (1990). Here, all of the elements of issue preclusion are met. The May 3, 1991 order represents a valid and final judgment after actual litigation of the issue of the scope of the January 10, 1991 acceptance. Furthermore, that issue was essential to the May 3, 1991 order. Therefore, the insurer may not relitigate the issue of the scope of its acceptance.

Extent of Scheduled Permanent Disability

The Referee found that claimant failed to prove entitlement to scheduled permanent disability benefits. We agree.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), "only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1991). Here, claimant did not request the appointment of a medical arbiter. Therefore, as the Referee found, any impairment findings must be made by the attending physician at the time of claim closure. Contrary to claimant's argument, the Referee did not find that claimant had no attending physician because she treated with several physicians at Kaiser Permanente. Instead, he found that none of the physicians at Kaiser Permanente who treated her provided any impairment ratings. We agree with that finding.

Claimant argues that the reports of Dr. Storrs, dermatologist, and Dr. Karty, M.D., should be used to determine her entitlement to scheduled permanent disability. These reports were generated as the result of independent medical examinations requested by the insurer. Because these physicians are neither medical arbiters nor attending physicians at the time of claim closure, their reports may not be used in rating claimant's impairment. ORS 656.245(3)(b)(B); ORS 656.268(7); Dennis E. Connor, supra.

Claimant argues that we held in Arlene J. Koitzsch, 44 Van Natta 776 (1992), that where a treating physician's impairment rating is defective, an independent medical examiner's report may be used to rate impairment. Claimant misunderstands our decision in that case. In Koitzsch, the Referee relied on an IME to rate impairment. The claimant appealed the Referee's order contending that the impairment should have been rated based on the findings of Dr. Johnson, her attending physician at the time of claim closure. We found that there was some question as to whether Dr. Johnson qualified as claimant's attending physician. However, even assuming that Dr. Johnson was claimant's attending physician, we found his opinion unpersuasive for several reasons. We noted that we considered the IME's opinion only for the purposes of supporting or impeaching the opinions and ratings offered by Dr. Johnson, not for its impairment findings. Although there was no persuasive impairment findings from the attending physician at the time of claim closure, the insurer did not ask for a reduction of the disability award, and solely for that reason, the award was not reduced. Id. at 178. We adhere to our conclusion in Dennis E. Connor, supra, that only a medical arbiter or the attending physician at claim closure may make findings regarding the claimant's impairment. Dennis E. Connor, supra.

Here, Dr. Storrs is a professor in the Department of Dermatology at OHSU and works in the Contact Dermatitis Clinic there. In 1988, claimant was referred to that clinic by a physician at Kaiser Permanente for patch testing. (Ex. 1-3, 6-1). Claimant argues that, because of this referral for testing, Dr. Storrs qualifies as her attending physician. We disagree. The record contains no evidence that Dr. Storrs became claimant's attending physician as a result of this referral. There are no reports in the record from Dr. Storrs other than his November 8, 1990 report which issued as the result of an independent medical examination and patch testing requested by the insurer. Dr. Storrs' reports are made as an IME, not as a consulting or attending physician.

Claimant argues that all physicians at Kaiser Permanente qualify as her attending physician. Therefore, claimant argues, Dr. Karty became claimant's attending physician by virtue of the fact that he is a physician at Kaiser Permanente. However, Dr. Karty examined claimant at the request of the insurer. He provided no treatment. There is no evidence that Dr. Karty was claimant's attending physician at claim closure. Instead, Dr. Karty's report, like the report of Dr. Storrs, was made in his capacity as an IME.

Finally, we agree with the Referee that, even if we assume that Dr. Karty is claimant's attending physician by virtue of the fact that he works at Kaiser Permanente, his report does not establish the amount of impairment "due to" the compensable occupational disease as opposed to the preexisting dermatitis condition.

Accordingly, we agree with the Referee that claimant has failed to prove the extent of ratable disability due to the compensable condition.

ORDER

The Referee's order dated May 4, 1992 is affirmed.

In the Matter of the Compensation of
**JAMES A. SMITH, Claimant**
WCB Case No. 91-15573
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last two paragraphs.

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Matter

The employer has submitted copies of the court's recent decision in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). The parties are not prohibited from bringing to the Board's attention recent decisions issued after completion of the briefing schedule. Betty L. Juneau, 38 Van Natta 553, 556 (1986).

Under the Juneau rationale, the submission of supplemental authority is permissible. However, no supplemental argument from any party regarding the application of Nazari to the facts of this case will be considered. Betty L. Juneau, supra.

### Compensability

The Referee upheld the employer's denial of degenerative disc disease, but concluded that claimant had proven compensability of his current condition, a disc herniation at L5-S1. We agree.

Whether claimant's L5-S1 disc herniation is related to the compensable injury or to degenerative disc disease is a complex medical question which must be resolved by expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967). Three physicians address the causation of the herniation. Dr. Streitz, an orthopedic surgeon, opined that claimant has a degenerative diskogenic process that is not related to work. Dr. Streitz stated:

> "I feel that his current condition and need for referral to Dr. Freeman and subsequent surgery relate to his degenerative condition and not to his work activities for any injury and in fact I wasn't aware of any work injury in my rather detailed intake history and physical. He has had some chronic episodic lumbosacral strain symptoms since 1987."

Dr. Serranzana treated claimant for the 1988 compensable injury until 1991 when he referred claimant to Dr. Streitz. Dr. Serranzana signed a statement stating that he concurred with Dr. Streitz that claimant's current condition and need for treatment was related to the degenerative condition rather than the work injury.

Dr. Streitz referred claimant to Dr. Freeman, a neurosurgeon, for treatment of the disc herniation. Freeman disagreed with Dr. Streitz and indicated that the radicular pain which claimant has had since the 1988 injury is consistent with the herniation he found and surgically removed at L5-S1. Dr. Freeman felt that the herniation occurred in 1988 as a result of trauma due to the compensable injury.

We find Dr. Streitz' history to be inaccurate. Consequently, we are not persuaded by his opinion. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Dr. Streitz seemed to be unaware that claimant had suffered a work injury and was confused about whether claimant's back

problems began in 1987 or 1988. Furthermore, he was not aware that claimant had lost time from work in 1990 as a result of his back condition. We are also unpersuaded by Dr. Serranzana's opinion, which is conclusory and lacking in explanation or analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980). We find Dr. Freeman's opinion to be based on a complete and accurate history and to be the best reasoned opinion in the record. Accordingly, we defer to Dr. Freeman's opinion that the herniation was caused by the 1988 injury. Somers v. SAIF, 77 Or App 259, 263 (1986). Based on this record, we conclude that claimant has established the compensability of his current condition.

The employer contends that Dr. Freeman's opinions should be discounted because they are based on an inaccurate history of constant leg pain since the 1988 injury. We do not agree that Freeman's history is inaccurate. The Referee found claimant credible based in part on his demeanor. Claimant testified that the radicular pain into the right leg was always present after the injury, but would diminish in between the more serious exacerbations. Furthermore, claimant did not have back pain or radicular pain prior to the 1988 injury. Based on claimant's testimony which the Referee found credible, we accept the history that claimant had radicular pain radiating into the leg since the 1988 injury which would diminish in between exacerbations. Accordingly, we do not agree that Dr. Freeman's history is inaccurate.

Finally, the employer contends that ORS 656.005(7)(a)(A) or (B) should apply to this case. However, we interpret Dr. Freeman's opinion as indicating that the herniation was a primary consequence of the 1988 injury, rather than a secondary consequential condition. Accordingly, ORS 656.005(7)(a)(A) would not apply. Albany General Hospital v. Gasperino, 113 or App 411 (1992).

As to the insurer's contention that ORS 656.005(7)(a)(B) applies, there is no evidence regarding whether the degenerative condition preexisted the 1988 injury or combined with the injury to cause or prolong disability or a need for treatment. According to Dr. Streitz, the herniation resulted solely from the degenerative condition, whereas according to Dr. Freeman, the herniation resulted solely from the compensable injury. Consequently, we conclude that ORS 656.005(7)(a)(B) does not apply. Alternatively, if claimant's degenerative disease did combine with his compensable injury to cause or prolong disability or a need for treatment or if it is a secondary consequence of the compensable injury, we would conclude, based on Dr. Freeman's opinion, that the injury is the major contributing cause of the disability or need for treatment. See Tektronix v. Nazari, supra.

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 compensability issue is $750, 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 April 30, 1992 is affirmed. For services on review, claimant's attorney is awarded $750 payable by the self-insured employer.

In the Matter of the Compensation of
**PHILIP A. STERLE, JR., Claimant**
WCB Case No. 91-07434
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bottini & Bottini, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Crumme's order that: (1) declined to consider Exhibits 61A and 62A for the purpose of rating claimant's impairment; (2) found that claimant's back injury claim was not prematurely closed; (3) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 10 percent (15 degrees); and (4) increased claimant's unscheduled permanent disability award for a low back injury from 36 percent (115.2 degrees), as awarded by an Order on Reconsideration, to 43 percent (137.6 degrees). The insurer cross-requests review of that portion of the order that directed it to pay claimant's scheduled permanent partial disability award at $305 per degree. On review, the issues are evidence, premature closure, extent of scheduled and unscheduled permanent disability, and rate of scheduled permanent disability. We affirm in part, modify in part, and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. We replace findings 19 and 21 with the following.

The parties stipulated that the Order on Reconsideration award of 5 percent bilaterally for the loss of use or function of claimant's left and right legs was correct, although claimant argued that he was also entitled to additional scheduled permanent disability.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

Dr. Wayson, neurosurgeon, was claimant's attending physician at claim closure. He referred claimant to a work hardening program at the Providence Hospital following claimant's back surgery. (Exs. 55, 56). On September 4, 1990, following claimant's completion of that program, Dr. Wayson found claimant medically stationary and adopted the Providence Hospital's analysis of claimant's level of disability and work restrictions. (Ex. 59). In February 1991, following the September 1990 Determination Order and before the July 1991 Order on Reconsideration, Dr. Slack, M.D., examined claimant; Exhibit 61A was generated as the result of this examination. Dr. Dixon, psychiatrist, also performed a record review in February 1991 which resulted in Exhibit 62A. The Referee refused to consider Exhibits 61A and 62A for the purpose of using the impairment findings to determine the extent of claimant's disability. We agree.

We have previously found that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), "only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1992). We decline claimant's request to overturn Dennis E. Connor, supra.

ORS 656.268(5) provides, in part:

> "At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

Claimant argues that, because ORS 656.268(5) refers to "any medical evidence" that should have been submitted at the time of closure, the statute does not require exclusion of subsequent medical reports on the basis that they were not generated by an attending physician. We disagree.

We recently addressed this same argument in Easter M. Roach, 44 Van Natta 1740 (1992), where we concluded that, pursuant to ORS 656.268(5), the term "any medical evidence" refers to evidence generated by claimant's attending physician at the time of claim closure. We found such an interpretation to be consistent with both our decision in Connor, supra and with the remainder of the language within the statute itself. ORS 656.268(5). Furthermore, we found that any decision to the contrary (e.g., that would permit the admission of evidence from IME's or other physicians) would contravene the statutory intent of ORS 656.245(3)(b)(B).

Here, neither Dr. Slack nor Dr. Dixon were claimant's attending physician at claim closure. Furthermore, Dr. Wayson, the attending physician at claim closure, adopted the disability and work restriction findings of the Providence Hospital's work hardening program. He did not adopt the post-claim closure findings of Drs. Slack and Dixon. Under these circumstances, we conclude that the Referee was correct in refusing to consider Exhibits 61A and 62A for the purpose of rating claimant's disability.

Premature Closure

We adopt the Referee's reasoning and conclusions regarding the issue of premature closure.

Extent of Scheduled Permanent Disability

We adopt the Referee's reasoning and conclusions regarding the issue of extent of scheduled permanent disability with the following correction.

The Referee found that the parties stipulated to a value of 5 percent bilaterally for loss of plantar sensation in his feet. However, we find that the parties actually stipulated that the Order on Reconsideration award of 5 percent bilaterally for loss of use or function of claimant's legs was correct, although claimant argued he was entitled to additional scheduled disability. (Exs. 61, 64, Tr. 3). Nonetheless, this minor error makes no difference in the total scheduled permanent disability to which claimant is entitled. We agree with the Referee that claimant established additional entitlement to scheduled permanent disability only in the form of a chronic condition limiting repetitive use of his right leg. (Exs. 54-4, 56, 58-2, 59). Thus, his total scheduled permanent disability is 5 percent for loss of use or function of his left leg and 10 percent for loss of use or function of his right leg.

Extent of Unscheduled Permanent Disability

We adopt the Referee's reasoning and conclusions regarding the extent of unscheduled permanent disability with the exception of the value assigned for the adaptability factor.

The Referee applied the correct standards. Here, claimant became medically stationary on September 4, 1990 and his claim was closed by Determination Order on September 26, 1990. The rules in effect on the date of the Notice of Closure or Determination Order control. Thus, the rules in effect from January 1, 1989 through September 30, 1990 (See WCD Admin. Order 6-1988), apply. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003 & former OAR 436-35-003.

We agree with the Referee that, because claimant has not returned to work and no work has been offered, former OAR 436-35-310(4) is the proper rule to use in determining his adaptability factor. We also agree that claimant's current physical capacity is between light and medium. (Exs. 58, 59). However, we find that claimant has additional limitations in his ability to sit, stand, and walk. (Ex. 58-3, 59).

Former OAR 436-35-310(4) provides, in pertinent part, "[w]hen a worker can perform above the requirements of one category but has limited ability to sit, stand, etc., the value shall be the average of the category their strength qualifies them for plus the values of the categories immediately above and below." Here, claimant can perform above the requirements of the light category but has limited ability

to sit, stand, and walk. The average of the light (4), medium (1), and sedentary (8) categories is 4.33. Thus, claimant's adaptability factor is 4.33.

Having determined each of the values necessary under the "standards", claimant's unscheduled permanent disability may be calculated. The sum of the value (0) for claimant's age and the value (3) for claimant's education is 3. The product of that value and the value (4.33) for claimant's adaptability is 12.99. The sum of that product and the value (35.5) for claimant's impairment is 48.49. That value is rounded to 49 percent. Former OAR 436-35-280(7). Thus, claimant is entitled to 49 percent unscheduled permanent disability.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated March 11, 1992 is affirmed in part, modified in part, and reversed in part. In addition to the Referee's and Order on Reconsideration awards of unscheduled permanent partial disability totalling 43 percent (137.6 degrees), claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving him a total award to date of 49 percent (156.8 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order; however, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800. That portion of the order that directed the insurer to pay the scheduled permanent disability award at $305 per degree and awarded an "out-of-compensation" attorney fee payable from this increased compensation is reversed. Claimant's scheduled permanent disability award is to be paid at the rate in effect at the time of his compensable injury. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**LYNN GEELAN, Claimant**
WCB Case No. 91-16494
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Howell's order that set aside its 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.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established a compensable aggravation of her low back condition. We adopt the Referee's reasoning and conclusions regarding this issue with the exception of

his discussion of whether the major contributing cause of claimant's worsened condition was the extended periods of driving during her vacation in August 1991. Although we agree with the Referee that claimant's claim is not defeated on that basis, we offer the following analysis.

As a general rule, a compensable aggravation is 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, the worsening is not compensable if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment. Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992).

The Referee held that claimant's driving activities while on vacation could not be an "injury" as that term is used in ORS 656.273(1) because they were a series of activities rather than a specific, identifiable incident. However, subsequent to the Referee's order, we held that an off-the-job injury may include an injury caused by repetitive activities, as well as an injury resulting from a discrete injurious event. Lucky L. Gay, 44 Van Natta 2172 (1992). Thus, activities such as driving can, in theory, constitute an injury occurring outside the course and scope of work.

On the other hand, the Referee also concluded that claimant had the burden of proving that an off-the-job injury was not the major contributing cause of her aggravation. The Referee did not, however, evaluate the evidence concerning causation based on his determination of which party had the burden of proof, but determined instead, that driving activities could not constitute an injury for purposes of ORS 656.273.

Subsequent to the Referee's order, we held that, if the insurer denies an aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the insurer has the burden of proving it. Roger D. Hart, 44 Van Natta 2189 (1992). Therefore, the insurer had the burden to prove by a preponderance of the evidence the truth of its assertion that claimant's driving activities were the major contributing cause of the worsened condition.

As noted above, we agree with the Referee that claimant established that the compensable injury was a material contributing cause of her worsened condition. At hearing and on review, the insurer asserted that claimant's driving activities while on vacation were the major contributing cause of her aggravation. We find that the insurer failed to meet its burden of proving this assertion.

The issue of whether claimant's vacation driving activities were the major contributing cause of her worsened condition is a complex medical question. 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).

Dr. Teller, M. D., treated claimant following the compensable work injury and remains her treating physician. He was aware of claimant's increased symptoms following her driving activities while on vacation and opined that claimant's symptoms did not represent a new condition. However, he stated that he was uncertain of what was the major contributing cause of claimant's symptoms. (Ex. 25).

The only other medical opinion regarding claimant's aggravation is from Dr. Wilson, neurologist, and Dr. Neufeld, orthopedist, who performed an independent medical examination. (Ex. 28). However, they render no opinion as to whether the major contributing cause of claimant's condition is her vacation driving activities. In fact, their report makes no mention of these driving activities.

On this record, we find that the insurer has failed to meet its burden of proof. Accordingly, we agree with the Referee that claimant has established a compensable aggravation claim.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 aggravation issue 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 February 25, 1992 is affirmed. For services on review, claimant's attorney is awarded $750, to be paid by the insurer.

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In the Matter of the Compensation of
**PAULA J. GILMAN, Claimant**
WCB Case No. 91-14264
ORDER OF ABATEMENT
Karen M. Werner, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our December 30, 1992 order that affirmed the Referee's award of 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of her right leg and foot. Specifically, SAIF argues that we erred in finding that: (1) Dr. Collada was claimant's attending physician at the time of claim closure; (2) Dr. Collada concurred with the independent medical examination (IME) report of Dr. Bachulis; and (3) Dr. Bachulis' IME report supports our impairment finding.

In order to consider SAIF's motion, we withdraw our December 30, 1992 order. Claimant is granted an opportunity to submit a response to the motion within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RONALD J. LAKEY, Claimant**
Own Motion No. 92-0644M
OWN MOTION ORDER
Brothers, Drew, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

The insurer has advised us that, on August 3, 1992, it denied claimant's aggravation claim prior to realizing that the claim was in own motion status. The insurer also indicated that it is unable to complete an own motion recommendation concerning any reopening of claimant's June 9, 1984 low back injury claim pending a determination from the Medical Director as to whether the proposed surgery is reasonable and necessary. However, we find that claimant's claim is not within our own motion jurisdiction.

ORS 656.273(4)(a) provides that a claim for aggravation of a disabling injury must be made within five years of the first claim closure. ORS 656.278(1)(a) provides the Board with sole jurisdiction for "aggravation" claims filed after the five year period has expired. However, the Board's own motion authority extends only to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

Here, although claimant was apparently injured in June 1984, his claim was not filed or processed until 1985. The insurer received notice of the claim on November 11, 1985. Subsequent to that date, the insurer accepted the claim as nondisabling. However, on May 21, 1986, the insurer submitted a 1502 form changing the status of the accepted claim from nondisabling to disabling. Thus,

claimant's nondisabling claim became disabling within one year from the time the claim was accepted. Under this circumstance, claimant's five year aggravation rights run from the date of the first closure of the claim. David E. Kennedy, on recon, 44 Van Natta 1455 (1992); Darrell K. Falline, 42 Van Natta 919 (1990); Richard M. Egli, 41 Van Natta 149 (1989). Inasmuch as claimant's claim was first closed on October 4, 1988, his aggravation rights do not expire until after October 4, 1993.

Accordingly, we lack own motion jurisdiction to consider any request for claim reopening. Instead, the insurer should process this claim as an aggravation claim pursuant to ORS 656.273.

IT IS SO ORDERED.

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January 27, 1993 Cite as 45 Van Natta 123 (1993)

In the Matter of the Compensation of
**KARRI J. MANITSAS, Claimant**
WCB Case No. 91-13173
ORDER OF ABATEMENT
Richard F. McGinty, Claimant Attorney
Garrett, et al., Defense Attorneys

Claimant has requested reconsideration of our December 31, 1992 Order on Review. Specifically, claimant contends that we erred in stating that only her right wrist deQuervain's disease was compensable rather than both wrists.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. The self-insured employer is requested to file a response within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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January 27, 1993 Cite as 45 Van Natta 123 (1993)

In the Matter of the Compensation of
**RHONDA E. PURDY, Claimant**
WCB Case No. 90-00610
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
John Pitcher, Defense Attorney

The self-insured employer requests reconsideration of our December 30, 1992 Order on Review which: (1) applied pre-1990 law to find that the Hearings Division has jurisdiction of claimant's request for hearing on a Determination Order; and (2) awarded additional benefits for temporary total disability and unscheduled permanent disability. Specifically, the employer contends that we erred in applying pre-1990 law. The employer also requests that this matter be reviewed by the Board en banc.

Contrary to the employer's argument, our order does not state that the Department of Insurance and Finance lacks authority to decide whether a claim was prematurely closed by determination order. Rather, our order merely clarifies which claims may be reviewed by the Board and which may be reviewed by the Department. In this case, because the September 1990 Determination Order found claimant to be medically stationary before July 1, 1990, her claim was properly reviewable by the Board and its Hearings Division pursuant to the law in effect before the 1990 amendments.

The employer argues that, in those cases where a claimant is asserting that the determination order or notice of closure has prematurely closed his claim, it is not absurd to require the claimant to file, as a precaution, both a request for hearing with the Board and a request for reconsideration with the Department. We disagree.

Under the employer's interpretation, a claimant would be forced to litigate the same issues before separate forums simultaneously, leading to separate appeals as well, and the authority of a particular forum to decide those issues would not be resolved until claimant's medically stationary date was finally determined. This process of reviewing disability awards would be complex, duplicative, costly and time consuming. As we stated in our prior order, our interpretation of the statutory scheme avoids these undesirable results while also effectuating the legislature's stated policy of reducing litigation to the greatest extent possible.

Furthermore, we are not persuaded that the employer's example on page three of its motion demonstrates any error in our decision. In that example, the employer assumes that the claimant would request reconsideration by the Department of a notice of closure that finds him to be medically stationary prior to July 1, 1990. However, the medically stationary date deprives the Department of authority to review the notice of closure, and the claimant could, instead, request a hearing before a referee.

Finally, we deny the employer's request for en banc review of our December 30, 1992 order. While the Board may sit en banc in rendering a decision, it may also sit in panels. See Or Laws 1991, ch 954, § 3. When sitting in panels, a majority of a particular panel may issue the decision of the panel. See id. Our December 30, 1992 order was rendered as a panel decision by a majority of the panel. The employer has advanced no persuasive reason as to why this case should be reviewed en banc. Therefore, we decline to grant the employer's request. See Brenda K. Allen, 44 Van Natta 2476 (1992) (on reconsideration).

Accordingly, we withdraw our December 30, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our December 30, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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January 27, 1993 Cite as 45 Van Natta 124 (1993)

In the Matter of the Compensation of
**JACK W. SANFORD, Claimant**
WCB Case Nos. 90-05108 & 90-05109
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
VavRosky, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our January 13, 1993 Order on Review that did not assess an attorney fee for claimant's counsel's services on review. Claimant contends that he is entitled to an attorney fee for his counsel's services on review, because Reliance Insurance Company's (Reliance) appeal placed claimant's compensation at risk of reduction. Reliance's response has been received. Having received these parties' respective positions, we proceed with our reconsideration.

The record establishes that claimant's wage rate was higher while Reliance provided coverage than it was when Aetna Casualty Company (Aetna) insured the employer. (Tr. 25). Consequently, if responsibility was reassigned on Board review, claimant's temporary disability compensation would be reduced. Because claimant's compensation was at risk of reduction as a result of Reliance's appeal and we ruled that the compensation allowed should not be reduced, claimant is entitled to an attorney fee for his services on review under ORS 656.382(2). See International Paper Company v. Riggs, 114 Or App 203 (1992).

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 is $500, to be paid by Reliance. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved.

Accordingly, our January 13, 1993 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.

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January 28, 1993 Cite as 45 Van Natta 125 (1993)

In the Matter of the Compensation of
**MARIA N. FLORES, Claimant**
WCB Case No. 92-04086
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Michael V. Johnson's order that dismissed claimant's request for hearing from an Order on Reconsideration which affirmed a Determination Order that did not award permanent disability for her compensable back and leg injury. On review, claimant challenges the propriety of the Referee's dismissal order. We reinstate claimant's request for hearing and affirm the Order on Reconsideration.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

After an October 23, 1991 Determination Order issued awarding no permanent disability, claimant requested reconsideration. Contending that she had sustained permanent impairment, claimant sought a stay of further proceedings to allow the Director an opportunity to promulgate a rule under ORS 656.726(3)(f)(C) to address her impairment.

On March 13, 1992, an Order on Reconsideration issued. Claimant's request for the adoption of an amended rule was denied. In addition, the Determination Order was affirmed in all respects.

Claimant filed a request for hearing. The insurer moved to dismiss on the basis that the Hearings Division lacked jurisdiction to address the Director's action in declining to promulgate a new rule. The Referee agreed and allowed the motion to dismiss.

We agree with the Referee's conclusion that the Hearings Division (or the Board) is without authority to order the Director to adopt temporary rules regarding the disability standards. Nevertheless, we find that the Referee had subject matter jurisdiction over this matter even if he did not have the authority to grant the relief (remand to the Director) sought by the claimant. Therefore, it was improper for the Referee to dismiss claimant's request for hearing.

ORS 656.726(3)(f)(C) provides:

> "When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, * * * the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

We recently construed ORS 656.726(3)(f)(C) in Gary D. Gallino, 44 Van Natta 2506 (1992). In that case, we held that the statute reserves to the Director the decision as to whether the standards addressed a worker's disability. Accordingly, we concluded that the Hearings Division and Board lack authority to remand to the Director for adoption of temporary rules.

Here, claimant asserts that we have jurisdiction to review the Director's decision not to promulgate a temporary rule under ORS 656.726(3)(f)(C). We interpret such a contention to be that we have authority to decide that the standards do not address claimant's alleged permanent disability and to remand to the Director for adoption of a temporary rule. As discussed above, our decision in Gary D. Gallino, supra, was to the contrary. Therefore, we agree with the Referee's reasoning to the extent that he held that the Hearings Division was without authority to order the Director to promulgate a disability standards rule.

Notwithstanding the aforementioned conclusion, we hold that it was error for the Referee to dismiss claimant's hearing request. Pursuant to ORS 656.268(5), any party who objects to a Determination Order must first seek reconsideration of that order. Following issuance of the reconsideration order, should any party object to that order, that party may request a hearing under ORS 656.283 within 180 days (excluding the reconsideration period) after copies of the notice of closure or the determination order are mailed. ORS 656.268(6)(b).

Here, the Determination Order issued on October 23, 1991. Claimant requested reconsideration of the order pursuant to ORS 656.268(5). Asserting that she had suffered permanent impairment and a permanent loss of earning capacity due to her compensable injury, claimant sought an amendment of the Director's disability standards to accommodate her impairment. Claimant's request was received by the Director on December 9, 1991. The Order on Reconsideration issued on March 13, 1992, declining the request for an amended rule and affirming the Determination Order. On March 23, 1992, claimant's hearing request from that reconsideration order was filed with the Board. Inasmuch as claimant requested a hearing within 180 days of the Determination Order (excluding the reconsideration period), her request is timely. ORS 656.268(6)(b). Moreover, since any party objecting to a reconsideration order may request a hearing, we further find that claimant is entitled to a hearing regarding her challenges to that order. Id.

Here, claimant concedes that her objections to the determination order as affirmed by the order on reconsideration are confined to the "rule adoption" issue. (Appellant's Brief p. 3). Therefore, in light of our decision in Gallino, supra, claimant is not entitled to the relief requested. However, claimant's request for hearing was not subject to dismissal. Moreover, in the event claimant had raised additional issues relating to the order on reconsideration, claimant would have been entitled to a hearing on those issues also. See Dale A. Pritchett, 44 Van Natta 2134 (1992) (whether a party seeking reconsideration has raised an issue is a question of fact). In any event, considering claimant's argument and our decision, the Order on Reconsideration is affirmed.

ORDER

The Referee's order dated June 8, 1992 is reversed. Claimant's request for hearing is reinstated. The March 13, 1992 Order on Reconsideration is affirmed.

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In the Matter of the Compensation of
**DENNIS L. RUSSELL, Claimant**
WCB Case No. 91-11445
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Quillinan's order that dismissed his request for hearing based on lack of jurisdiction. On review, the issue is jurisdiction.

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

Contending that the insurer failed to respond to his attending physician's palliative care request within 30 days, claimant argues that the request is deemed approved and, thereby compensable, vesting

jurisdiction with the Hearings Division. Claimant relies on former OAR 436-10-041(4), which provided that if the attending physician did not receive written notice from the insurer within 30 days disapproving a palliative care request such a request "shall be approved." (Effective July 1, 1992, this rule was amended to provide for the assessment of civil penalties for the failure to timely respond to the request).

Assuming without deciding that the insurer is deemed to have approved the palliative care request, the fact remains that, as of the hearing date, claimant was apparently not receiving the treatment his physician has recommended. In other words, a dispute continued to exist regarding the request. Under such circumstances, it would be incumbent on claimant's attending physician to seek Director resolution of the controversy. See Rexi L. Nicholson, 44 Van Natta 1546 (1992); Gladys M. Theodore, 44 Van Natta 905 (1992). That is, whether the insurer would be deemed to have approved the treatment request under the former rule would be a question within the province of the Director, not this forum.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

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January 28, 1993 Cite as 45 Van Natta 127 (1993)

In the Matter of the Compensation of
**HOA M. TANG, Claimant**
WCB Case Nos. C2-03016 & C2-03017
ORDER ON RECONSIDERATION
Gatti, Gatti, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

On December 8, 1992, the Board received the parties' claim disposition agreements in the above-captioned matters. Pursuant to those agreements, in consideration of the payment of a stated sum, claimant released certain rights to future workers' compensation benefits, except medical services, for the compensable injury. As the dispositions complied with statutory requirements and applicable administrative rules, we approved the agreements on January 8, 1993.

On January 19, 1993 the Board received claimant's Motion for Reconsideration of the approved claims disposition agreements. On January 25, 1993 the Board issued an Order of Abatement in order to allow sufficient time to consider the motion and to allow the insurer to submit its position. On January 22, 1993, we received the insurer's response. We therefore proceed to address claimant's request for reconsideration.

Pursuant to OAR 438-09-035, we may reconsider final orders under ORS 656.236, provided that the motion for reconsideration: (1) is filed within 10 days of mailing of the final order; and (2) states specifically the reason reconsideration is requested. OAR 438-09-035 (1) and (2). Moreover, reconsideration 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. OAR 438-09-035(3).

Here, claimant's request for reconsideration was filed on January 19, 1993, which is within 10 days of the mailing of our order. Furthermore, claimant has specifically stated her reason for requesting reconsideration. Accordingly, we grant claimant's motion for reconsideration.

On reconsideration, claimant requests disapproval of the disposition captioned C2-03016 on the ground that claimant's treating doctor now recommends surgery that was not contemplated at the time the agreement was entered into. Claimant also requests disapproval of the approved disposition captioned C2-03017, on the ground that both disposition agreements were entered into at the same time as a "package deal".

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the request for reconsideration was received January 19, 1993. Because claimant's request for disapproval was not made within the statutory 30-day period, we have no authority to now disapprove either of the above captioned disposition agreements. Under the circumstances, we decline to grant claimant's request that we disapprove the disposition agreements.

Accordingly our January 8, 1993 orders are withdrawn. On reconsideration, as supplemented herein, we republish and adhere to our prior orders in their entirety.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CLIFFORD J. CHRISTIAN, Claimant**
WCB Case No. 91-15147
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Hooton, Kinsley, and Brazeau.

Claimant requests review of Referee T. Lavere Johnson's order which affirmed an Order on Reconsideration awarding no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

In determining the extent of disability, the Referee applied the "standards" in effect at the time of the May 31, 1991 Determination Order (WCD Administrative Order 2-1991). We agree and also apply those same standards in determining the extent of claimant's disability here.

The Referee concluded that claimant was not entitled to an impairment rating because he found that the condition was temporary and would not result in permanent impairment. On review, claimant argues that, because he is medically stationary and he continues to have chronic bilateral forearm pain which limits his repetitive use, he is entitled to compensation for a chronic condition under the standards. We agree.

Former OAR 436-35-010(6) allows an award of 5 percent for chronic conditions that limit the repetitive use of a scheduled body part. A scheduled "body part" means the foot/ankle, knee, hand/wrist, elbow, and arm. Id. A worker is only entitled to one 5 percent chronic condition award per extremity, regardless of how many body parts within the extremity have chronic conditions. Former OAR 436-35-010(6)(b). While lay testimony is probative, the existence of a chronic condition must also be established by the preponderance of the medical evidence. See former OAR 436-35-010(6); Catherine E. Green, 44 Van Natta 925, 927 (1992).

In the present case, claimant credibly testified that he experiences pain and aching sensations in his wrists and forearms with heavy repetitive work. (Tr. 20-24). Additionally, Dr. Steele, claimant's treating orthopedic surgeon, noted at claim closure that claimant continued to have chronic pain and aching sensations in both forearms with repetitive or strenuous activity. (Exs. 15, 16, 24). While Dr. Steele predicted the hope that claimant's chronic condition would resolve with time, claimant's testimony, and the agreement of all parties that claimant is medically stationary, establishes that it has not. Therefore, we conclude that claimant is entitled to an impairment value of 5 percent for loss of repetitive use of each forearm.

ORDER

The Referee's order dated January 23, 1992 is reversed. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of repetitive use of each of his forearms. 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 fee awarded by this order shall not exceed $3,800.

**Board Member Brazeau, dissenting:**

The majority concludes that claimant has established entitlement to a scheduled disability award in the form of impairment for a chronic condition. The majority reasons that because claimant is medically stationary and continues to experience limiting forearm pain, he must be entitled to compensation for a chronic condition.

Former OAR 436-35-007(1) provides that a worker is entitled to a value under the applicable standards "only for those findings of impairment that are permanent . . ." (emphasis added). Former OAR 436-35-010(2) provides that "Disability is rated on the permanent loss of use or function of a body part . . ." (emphasis added). Former OAR 436-35-010(3) provides that pain is considered in the applicable rules to the extent that it results in "objective measurable impairment." Former OAR 436-35-010(6) provides that a worker may be entitled to scheduled chronic condition impairment when medical opinion establishes that the worker is "unable to repetitively use a body part due to a chronic and permanent medical condition . . ." (emphasis added).

The evidence in this case, as supplied by claimant and his treating physician, Dr. Steele, is that: 1) claimant is medically stationary; 2) claimant has pain in both forearms that continued after his claim was closed; 3) claimant's pain has resulted in no measurable loss of range of motion or grip strength; 4) claimant's clinical test results have all been normal; 5) claimant is able to repetitively use his forearms, although he is restricted; and 6) claimant's chronic condition will resolve with time.

Thus, the evidence is that claimant's chronic condition is neither permanent nor has rendered him unable to repetitively use his forearms. He, therefore, does not qualify for an award of impairment due to a chronic condition under the applicable standards.

From this record, it appears to me that claimant's claim may have been prematurely closed. The sole issue at hearing, however, was the extent of permanent disability allegedly resulting from claimant's compensable injury. On the record before us, there is none. I, therefore, respectfully dissent.

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January 29, 1993 Cite as 45 Van Natta 129 (1993)

In the Matter of the Compensation of
**WILLIAM A. DRAKE, Claimant**
WCB Case No. 92-02265
ORDER ON REVIEW
Douglas L. Minson, Claimant Attorney
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of that portion of Referee Podnar's order that set aside its partial denial of claimant's coronary atherosclerotic heart disease (CAD and organic heart disease) and medical treatment related to that condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last paragraph on page 3 and supplement as follows.

On April 26, 1982, claimant was physically assaulted by a customer at work. Five days later, he suffered a severe myocardial infarction. (Exs. 1 and 2).

On August 6, 1982, SAIF denied claimant's "current heart condition." (Ex. 4).

The January 1984 Order on Review identified claimant's "condition" as an April 30, 1982 myocardial infarction. (Ex. 12).

After bypass surgery, claimant continued to have intermittent nonexertional episodes of chest pain (angina pectoris), for which he took nitroglycerin. (Ex. 14).

Claimant's 1988 hospitalization was for a transient cerebral ischemic attack that resulted in brief left-eye blindness (amaurosis fugax), for which Coumadin was prescribed.

In September 1989, claimant was hospitalized with aggravated chest pain secondary to unstable angina.

SAIF's February 5, 1992, partial denial stated:

> "You filed a claim for a work-related injury to your heart, which occurred on or about April 30, 1982, while employed at Bob's R.V. Country. The claim was accepted for myocardial infarction and benefits were provided according to law.
>
> "We have recently received information that you are seeking treatment for coronary atherosclerosis which you feel is related to your injury. After reviewing the information in your file, we are unable to pay for your current medical condition and treatment as it is not related to your compensable myocardial infarction."

Dr. Lee's deposition testimony differed from his opinion as expressed in paragraph 7 on page 2 of the Opinion and Order.

## FINDINGS OF ULTIMATE FACT

SAIF accepted claimant's 1982 myocardial infarction and any disability flowing therefrom.

The progression of claimant's preexisting, underlying coronary artery disease was the major contributing cause of his 1991 need for treatment and his 1991 myocardial infarction.

## CONCLUSIONS OF LAW AND OPINION

On April 26, 1982, claimant was physically assaulted at work by a customer. Five days later, he suffered an acute myocardial infarction. He filed a claim for a heart attack. He experienced post-infarction angina and exercise intolerance, and was unable to work. Dr. Starr performed a coronary bypass graft to the affected coronary arteries. On August 6, 1982, SAIF denied claimant's "current heart condition" as being unrelated to the incident that occurred at work. Claimant requested a hearing on the denial.

In an April 25, 1983 Opinion and Order, a referee concluded that claimant had established the compensability of his heart attack. In that order, the referee also stated that he had considered the fact that claimant had an underlying arteriosclerotic condition which probably predisposed him to the myocardial infarction. He concluded, however, that the infarction would not have occurred without the stressful event at work. The compensability of the myocardial infarction was upheld by a January 18, 1984 Order on Review. William A. Drake, 34 Van Natta 477 (1984).

On August 22, 1984, a Determination Order granted an award for permanent total disability effective July 12, 1984. This award was based on a 75 percent permanent impairment due to Class 2 organic heart disease. The Determination Order was not appealed by SAIF. Between 1983 and November 1989, claimant experienced chronic angina.

In November 1989, claimant was hospitalized for chest pain and underwent catheterization for evaluation. He was diagnosed with diffuse coronary artery disease and unstable angina pectoris. On August 2, 1991, claimant was hospitalized for chest pain. He sustained an acute myocardial infarction

during the hospitalization. On February 5, 1992, SAIF denied claimant's claim for coronary atherosclerosis on the basis that the condition and any treatment therefrom were not related to the compensable 1982 myocardial infarction.

The Referee concluded that, under the doctrine of res judicata, SAIF could not deny the compensability of claimant's current condition and need for treatment because: (1) the April 25, 1983 Opinion and Order required SAIF to accept claimant's "heart problems as of April 30, 1982 and disability flowing therefrom;" (2) the August 22, 1984 Determination Order that awarded permanent total disability was partly based on the Evaluation Section's impairment rating of class 2 organic heart disease; and (3) these orders had become final by operation of law.

In its brief, SAIF maintains that the Referee erred in concluding that SAIF was ordered to accept claimant's coronary artery disease (CAD) and all subsequent heart conditions, in that the 1984 and the 1992 hearings did not concern the same issues or operative facts. We agree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Issue preclusion acts as a bar only when: (1) the same parties (2) actually litigate an issue of law or fact (3) which is necessary to (4) a valid and final judgment.

Although the order language in the 1984 Opinion and Order requires SAIF to accept claimant's "heart problems as of April 30, 1982 and disability flowing therefrom," the sole issue before the referee was whether the cause of claimant's April 30, 1982 heart attack was claimant's underlying, preexisting atherosclerosis (coronary artery disease) or the stress brought about by the altercation at work. The Form 801 specified that the sole condition at issue was a "massive, massive heart attack." In the deposition of claimant's attending physician, the issue was to determine "whether or not [claimant's] myocardial infarction for which you have treated him originating 4/30/82 is compensable within the meaning of the Oregon Workers' Compensation codes." (Ex. 7-4). Within the Opinion and Order itself, the issue was again framed as whether the myocardial infarction was caused by the underlying coronary artery disease or by the altercation at work. Moreover, when Drs. Lee and Starr were deposed prior to the 1983 hearing, both physicians indicated that claimant's coronary artery disease was not related to his work. (Exs. 6-19 and 24-13). Accordingly, we conclude that the compensability of the underlying coronary artery disease was not before the prior referee.

Instead, the "actual litigation" concerned solely the compensability of claimant's myocardial infarction. It is clear from the evidence, the body of the prior referee's opinion, and the Order on Review that SAIF was ordered to accept claimant's 1982 myocardial infarction and the disability flowing therefrom.

Consequently, since the compensability of the coronary artery disease was never actually litigated, issue preclusion does not bar either party from now raising the compensability of the coronary artery disease.

Furthermore, the Determination Order merely awarded compensation for the permanent residuals of the myocardial infarction. It did not, and could not, order SAIF responsible for claimant's preexisting, underlying disease. Moreover, ORS 656.262(9) provides that paying or providing compensation shall not be considered acceptance of a claim.

Under the doctrine of claim preclusion, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, supra at 309; Restatement (Second) of Judgments, Sections 17-19, 24 (1982). A "claim" is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating, supra. Claim preclusion does not require actual litigation of an issue of fact or law; however, the opportunity to litigate is required, whether or not it is used, and there must be a final judgment. Drews v. EBI Companies, 310 Or 134, 140 (1990).

Inasmuch as the issue of compensability of the underlying coronary artery disease and the 1991 coronary infarction was not raised by the 1982 denial or the 1984 hearing, there was no prior opportunity to litigate the underlying condition. Moreover, the medical evidence indicates that

claimant's coronary artery disease has changed since the 1984 hearing so as to create a new set of operative facts that previously could not have been litigated. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989). Accordingly, the doctrine of claim preclusion does not bar SAIF from now denying claimant's underlying condition.

SAIF next argues that since res judicata issue preclusion does not bar its denial, the Referee necessarily meant that SAIF had issued an improper back-up denial of a previously accepted condition under Bauman v. SAIF, 295 Or 788 (1983). Claimant argues that the specifically accepted condition is defined by the 1983 Opinion and Order, which states that claimant's "heart condition" is remanded for acceptance.

Although the Referee did not frame the issue as one of an improper back-up denial, we address this argument as an alternative theory. Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Citing the acceptance requirements of ORS 656.262(6), the Court stated: "An insurer must accept a particular claim in writing * * * before Bauman applies." Johnson v. Spectra Physics, 303 Or 49 (1987). Here, SAIF did not specifically or officially accept claimant's coronary artery disease condition. Accordingly, the Bauman rule does not apply.

Because SAIF was not barred from denying claimant's claim for CAD, we turn to the merits of the compensability issue.

After reviewing the record, we conclude that claimant's current condition is not compensable. No medical opinion links his compensable 1982 claim or subsequent work exposure with his current condition, need for medical services or related disability.

The medical evidence establishes that claimant's coronary artery disease is an underlying and preexisting disease. Dr. Toren, cardiologist, reviewed claimant's file and opined that claimant's August 1991 hospitalization was related to the progression of his coronary artery disease and that the small myocardial infarction claimant sustained in 1991 was most likely due to a further progression of that disease process. Toren further opined that the 1982 myocardial infarction would not have caused a progression of claimant's underlying coronary artery disease. Dr. Toren explained that coronary artery disease is by its nature a progressive disorder, and that myocardial infarction has not been shown to cause coronary atherosclerosis to progress more rapidly than it would have in the absence of a prior infarction. (Ex. 23).

Dr. Lee, claimant's current treating physician, concurred with Dr. Toren, opining that claimant's 1982 myocardial infarction did not cause his subsequent 1991 myocardial infarction and did not cause a progression of claimant's underlying disease process. Dr. Lee also opined that the progression of the coronary artery disease was the major contributing cause of claimant's 1991 myocardial infarction and need for treatment. As to his initial opinion that claimant's current medical condition was related to his 1982 myocardial infarction, Dr. Lee clarified that he meant claimant's continuing symptoms of fatigue and lack of energy.

Based on the uncontroverted medical evidence, we conclude that neither claimant's 1991 myocardial infarction nor his underlying CAD are compensably related to the accepted 1982 claim.

## ORDER

The Referee's order dated June 3, 1992 is reversed. SAIF's denial, as amended, is reinstated and upheld. The Referee's $3,000 attorney fee award is reversed.

In the Matter of the Compensation of
**JAMES D. GRIFFIN, Claimant**
WCB Case No. 91-07703
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's right knee injury claim. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated December 17, 1991 is affirmed.

**Board Member Hooton dissenting.**

The majority affirms and adopts the Opinion and Order of Referee Podner dated December 17, 1991. Because that order is both legally and factually insufficient, I respectfully dissent.

The Referee correctly states that the issue is an appeal from the SAIF Corporation's May 6, 1991 denial of a claim for a right knee strain. (Ex. 16). Thereafter, the order concentrates explicitly on the compensability of claimant's chondromalacia. The analysis is inconsistent with that required by the Board's holding in Bahman Nazari, 43 Van Natta 2368 (1991).

In Nazari, the Board held that where a compensable injury combines with a preexisting condition, the insurer must accept the original injury if the claimant's industrial injury is a material contributing cause of the need for treatment. The insurer may, in the same or a separate document, deny compensation for the underlying preexisting condition and for treatment for which the preexisting condition is the major contributing cause.[1]

In the present dispute, the Referee found that claimant experienced a twisting injury to the knee which caused the development of symptoms of pain for a period of three or four days. Thereafter, the pain subsided. Claimant's testimony, however, indicates that swelling, which accompanied the injury, did not subside. Because the swelling did not subside, claimant sought diagnosis and treatment.

Where claimant experiences an injury with resultant symptomatology, claimant is entitled to know the nature and extent of any injury that may have resulted. Because the swelling that accompanied the twisting incident did not subside, claimant was entitled to obtain medical services to discover the nature and extent of any injury. Brooks v. D & R Timber, 55 Or App 688 (1982). On that basis, claimant has established a need for medical services related to the original injury and a valid claim for compensation.

The Referee, however, without regard for the right knee strain denied by the insurer, analyzed the compensability of claimant's current knee condition, chondromalacia of the patella, a condition that had not yet been denied. In analyzing that condition, the Referee appears to rely upon the opinion of Dr. Struckel, an employee of the insurer who conducted a records review on his employer's behalf, rather than the reports of claimant's treating physician. No other medical evidence is offered on the question of medical causation.

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[1] The Court of Appeals has subsequently rejected the analysis of the Board in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). In that case, however, only a single condition, or injury, was at issue. Here, claimant experienced a knee strain as a result of a witnessed fall, in which disability is prolonged by the fact that the injury made symptomatic a previously asymptomatic pre-existing condition. The denial of the right knee strain is not dependant upon a pre-existing condition and there is no evidence that a pre-existing condition combined with the fall to cause the original injury. Consequently, the right knee strain is still subject only to a material cause standard of proof.

The Referee discounts the opinion of Dr. Hoppert, the treating physician, finding that his reports are "bare conclusion" and "without support in the record." These findings are not supported by the record as a whole. In addition, the report of Dr. Struckel is based on facts contrary to the express findings of the Referee, and is, therefore, unreliable.

Dr. Hoppert opined that claimant's preexisting chondromalacia was made symptomatic by the injury of April 10, 1991. His conclusion is based upon claimant's history, which indicates that claimant had not received, or required, treatment to his right knee since a volleyball related exacerbation of a prior knee injury in April of 1987, four years prior to the present incident. The knee became symptomatic, however, following the industrial incident in April 1991, and those symptoms, especially the presence of effusion, or swelling, did not resolve as they had following the 1987 exacerbation. Based on that history, Dr. Hoppert concludes that the industrial incident is the major cause of claimant's disability and need for medical services. The only thing that Dr. Hoppert's reasoning presumes is that the asymptomatic preexisting condition would have remained asymptomatic if the twisting injury had not occurred. That reasoning is eminently logical and perfectly acceptable.

On the other hand, Dr. Struckel presumes a pattern of increasing frequency and duration of effusion and related symptomatology that is not supported by claimant's testimony or medical history. Indeed, Dr. Struckel concludes that claimant suffered no work injury. Consequently, he concludes that claimant's preexisting chondromalacia patella is the sole cause of claimant's current condition. The Referee found, and the majority has adopted, facts consistent with an injury, however minimal, related to claimant's employment. No other finding is possible on a record in which claimant could and did produce a witness who confirmed that claimant in fact fell and upon arising demonstrated physical characteristics consistent with a painful right knee.

Thus, contrary to Dr. Struckel's speculation, claimant did experience an injury. The only pertinent question for resolution is the extent of that injury. Because Dr. Struckel relies upon a history that is contrary to the specific findings of fact of the Referee and the Board, his opinion is not reliable and must be disregarded. Somers v. SAIF, 77 Or App 259, 263 (1986); Kuhn v. SAIF, 73 Or App 768, 772 (1985).

On these facts, I have no option but to find that claimant has established a compensable right knee injury. In addition, though the condition was never actually denied by SAIF, claimant has established the compensability of a subsequent need for treatment for the combined effects of his industrial injury and his preexisting chondromalacia. The contrary opinion of the Referee, as adopted by the majority is not supported by any reliable evidence in the record, and conclusions regarding the reports of Dr. Hoppert are facially inaccurate. The Opinion and Order of December 17, 1991 must be set aside. Because the majority would affirm and adopt that order, despite its inaccuracies and the unreliability of Dr. Struckel's opinion, I respectfully must dissent.

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In the Matter of the Compensation of
**JUDY A. JACOBSON, Claimant**
WCB Case No. 91-16843
SECOND ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The insurer requests reconsideration of our December 1, 1992 Order on Review, as reconsidered on December 16, 1992. On January 8, 1993, we abated our prior orders to allow claimant an opportunity to respond. Having received claimant's response, we now proceed with our reconsideration.

On reconsideration, the insurer first argues that "the Board uses the 1990 standards when the 1991 standards were appropriate as used by the Appellate Division." Presumably, the insurer is referring to the fact that, on reconsideration, the Appellate Review Unit applied the temporary standards except when determining range of motion, explaining that, "[b]ased on the new medical rules which went into effect 10-1-91 [WCD Admin. Order 7-1991], all spinal ROM findings are reported by

inclinometer thereby necessitating the use of the 4-1-91 standards [WCD Admin. Order 2-1991] for this portion of the impairment evaluation." (Ex. 18-4).

WCD Admin. Orders 2-1991 and 7-1991 "shall be applied to all claims closed on or after April 1, 1991, for workers medically stationary after July 1, 1990." Former OAR 436-35-003(1). Furthermore, for those claims in which the worker was declared medically stationary after July 1, 1990, "the Appellate Unit shall apply the disability rating standards in effect on the date of issuance of the Determination Order or Notice of Closure." Former OAR 436-35-003(2). WCD Admin. Order 7-1991 also provides that the "provisions of OAR 436-35-360(2) through (11) only apply to closing exams performed prior to October 1, 1991." Former OAR 436-35-003(3).

As our Order on Review stated, claimant was declared medically stationary after July 1, 1990 (on February 8, 1991) and the Determination Order issued on March 15, 1991. Therefore, under former OAR 436-35-003(1) and (2), WCD Admin. Orders 2-1991 and 7-1991 are not applicable.

Furthermore, if the Appellate Review relied on former OAR 436-35-003(3) (WCD Admin. Order 7-1991) in applying WCD Admin. Order 2-1991 to range of motion findings, we find that such reliance was erroneous. We interpret this provision in conjunction with former OAR 436-35-003(1), thereby providing that OAR 436-35-360(2) through (11) apply if the closing examination was performed before October 1, 1991 and the claim was closed on or after April 1, 1991 and claimant was declared medically stationary after July 1, 1990.

Because claimant's claim was closed before April 1, 1991, we find that OAR 436-35-360(2) through (11), as provided in WCD Admin. Orders 2-1991 and 7-1991, are not applicable. Consequently, we adhere to our former conclusion that the extent of claimant's unscheduled permanent disability properly is determined under WCD Admin. Order 6-1988, as modified by WCD Admin. Orders 15-1990 and 20-1990.

With regard to the insurer's second argument, it contends that our first Order on Reconsideration erroneously awarded 25 percent of the increased unscheduled permanent disability award granted by the Referee and Board orders. We find that our first order on reconsideration adequately explains the basis for our conclusion and we continue to adhere to our prior conclusions regarding the attorney fee award.

On reconsideration, claimant argues that the Referee's scheduled permanent disability award should have been affirmed. After reviewing claimant's argument on that issue, we continue to adhere to our prior conclusion on the issue of scheduled permanent disability.

Finally, claimant has requested an attorney fee for services provided in responding to the insurer's request for reconsideration. We agree that, because the insurer has effectively requested a reduction in claimant's unscheduled permanent disability award, by contesting our application of the standards claimant is entitled to an assessed attorney fee for successfully defending against the insurer's reconsideration request.

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 reconsideration is $150, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue of unscheduled permanent disability (as represented by that portion of claimant's reply on reconsideration), the complexity of the issue, and the value of the interest involved. We note that no attorney fee is available for services provided with regard to the attorney fee issue or claimant's unsuccessful cross-request for reconsideration on the issue of scheduled permanent disability.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our December 1, 1992 Order on Review and December 16, 1992 Order on Reconsideration in their entireties. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**JUANA PIPER, Claimant**
Own Motion No. 92-0421M
OWN MOTION ORDER
Scott McNutt, Claimant Attorney

The insurer has submitted claimant's request for temporary disability compensation for her compensable lumbar injury. Claimant's aggravation rights expired on June 2, 1992. The insurer opposes authorization of temporary disability compensation, contending that claimant had withdrawn from the work force before her condition worsened.

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 conclude that claimant has sustained such a worsening. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof on this issue.

Here, by claimant's own affidavit, she began treating with Dr. Matteri in August 1992, and has been unable to work since that time due to a worsening of her compensable low back condition. Claimant submitted copies of W-2 forms for 1990 and 1991 earnings. However, she offers no proof of employment in 1992. In a history given during a December 17, 1992 IME, claimant reported that she last worked in February 1992. There is no evidence claimant was willing to work, made reasonable efforts to find work, or that it was futile to do so from February until her worsening in August 1992.

Accordingly, claimant's request for temporary disability compensation is denied. See id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**SHIRLEY S. SCAPARRO, Claimant**
WCB Case Nos. 91-05952 & 91-07759
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hooton, Brazeau, and Kinsley.

Claimant requests review of Referee Myzak's order which: (1) found that claimant's occupational disease claim for a thoracic outlet syndrome condition was barred by res judicata and upheld the self-insured employer's denial; (2) set aside the employer's denial of claimant's injury claim for left arm conditions; and (3) awarded claimant's attorney an assessed fee of $1,500 for services at hearing. The employer argues that the attorney fee award is excessive. On review, the issues are res judicata, compensability and attorney fees.

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

The Referee awarded claimant's attorney an assessed fee of $1,500 for services at hearing. The employer contends that this award is excessive. We disagree.

OAR 438-15-010(4) sets forth the following factors considered in determining a reasonable fee: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorney; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After review of the record at hearing, and considering the above factors, we conclude that the Referee's award is reasonable. In reaching this conclusion, we have particularly considered the complexity of the credibility issue, the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to a fee for services on review regarding the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 27, 1992 is affirmed. The Board's July 4, 1992 Interim Order Dismissing Cross-Request for Review is incorporated by reference into this order and affirmed.

**Board Member Kinsley dissenting.**

This case illustrates the unfortunate result of the lack of adequate rules for the award of attorney fees at hearing and on Board review. Such rules would provide for the presentation of law and facts by the parties which would provide a basis for the award of an appropriate attorney fee to claimant's attorney. There is presently no requirement that a claimant's attorney submit one scrap of information upon which a referee or this Board can make an informed decision on the appropriate attorney fee to be awarded. This means there is a greater potential for the parties to question the basis for the awards that are made.

Here, the employer has raised legitimate concerns regarding a $1500 fee that they have been ordered to pay to claimant's attorney regarding a left forearm strain/bruise claim. They contend that the fee should be reduced. The claimant has provided little information upon which to evaluate these concerns. However, a review of the file, aided by employer's brief, reveals the following:

The issue for which claimant seeks a fee was not complicated. It involved whether a left forearm strain and bruise was work related and, therefore, compensable as a workers' compensation claim. There were seven pages of directly relevant documents in the record. The medical opinion was

uncomplicated in that it was contained in a few sentences from a qualified medical doctor and was uncontradicted. There were no depositions taken in the case. Claimant's attorney conducted examination of his client (the sole witness at hearing) on this issue and responded to the employer's cross-examination regarding possible off-the-job causes for the strain/bruise and the reliability of claimant's history. Claimant's opening statement and closing argument on this issue were not extensive. It appears from the length of the typed transcript that the entire hearing took about one to one and one-half hours. There is nothing in the file to indicate that there were any special circumstances requiring additional time or effort by claimant's attorney. (There were other issues raised at hearing that included other exhibits, testimony and argument. However, claimant is not asserting that these other issues could be the basis for a fee.)

As to the benefit to claimant, the left forearm strain/bruise resulted in claimant obtaining payment for medical services for one office visit and one telephone call with the doctor. Claimant is apparently not entitled to any benefits for temporary or permanent disability since she lost no time from work due to the bruise and there is no indication that the bruise resulted in permanent disability.

OAR 438-15-010(4) sets out the bases for an attorney fee:

(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 of the attorney,
(e) the nature of the proceedings,
(f) the benefit 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.

When the employer requested reconsideration of the $1500 fee at the Hearings Division, claimant's attorney responded in a five paragraph letter to the Referee. The first four paragraphs correctly asserted that claimant had a valid claim and that legal representation was necessary to get the claim accepted. In my view, this affirmed the fact the claimant's attorney was entitled to a fee, yet still gave no basis for the appropriate amount. Claimant also asserted that this case was different from another case cited by the employer (in which a referee had reduced a fee) because, unlike that case, the issue here had been raised prior to hearing. In the last paragraph, claimant's attorney stated:

> "Thus, this case is considerably different than the case cited by [employer's counsel], and even though it would be difficult to specifically state how much time was involved on each claim or issue, it certainly does not seem unfair for an award of $1500 attonrey [sic] fees for overturning a denial, since in numerous other cases I have had awards considerably in excess of this amount."

This is the only detail received from claimant regarding the factors from the above rule. Claimant submitted neither an appellant brief nor a reply brief on Board review. It may be that $1500 is an appropriate fee to be awarded in this case. However, it is impossible to determine that from the record before us.

The Hearings Division and this Board decide all other issues based on the facts and the law. However, when it comes to deciding how much an employer or insurer should pay a claimant for an assessed attorney fee, we've abandoned that legitimate and time-honored method. As a staff attorney for the Board, as a referee and, presently, as a Board member, I've had the responsibility to recommend or award the amount for attorney fees. In my view, the method that we presently use is untenable. There is an unwritten minimum and maximum amount that staff attorneys, referees and Board members have in our heads when we make awards. Different people have different minimum and maximum numbers. From my experience, these numbers are obtained from "asking around" at the office and based on what has typically been awarded in past years. There is little factual basis for the numbers. The actual amount settled on is based on "eyeballing" the case and coming up with a ballpark number within the unwritten guideline amounts based on how hard or easy the issues seemed and how helpful the attorney's actions, verbal or written work was to the decision maker. The decision maker who is

trying to come up with a fair award, although filled with good intentions, may have never tried a similar workers' compensation case, written a legal brief on a similar issue, practiced on a contingency fee basis or had to operate a legal office. Or, if they did, it may have been so long ago that the fees, hours or billings they remember are no longer relevant to today's world.

Further, our awards are not based on a regularly conducted survey of hourly rates, time needed to try a typical (or not so typical) case, the financial realities of accepting cases on a contingency basis, or of trying to operate a law office. Most importantly, they are not based on the claimant's attorney's statement of facts in a particular case regarding the factors set out in our own rule regarding the setting of an attorney fee. (In the rare case, a claimant's attorney will provide the information on their own motion.) Even if the Board did conduct some kind of regular survey to determine the "typical" fee and circulated a published minimum and maximum amount guideline, this method of awarding a fee still would do a disservice to both parties.

The claimant's attorney deserves to be compensated with the fee he or she fairly earned in a particular case, no more and no less. The employer or insurer deserves to pay only for the fee required to be paid in a particular case, no more and no less. This is the longstanding and accepted practice used in all the courts of this State. Lawyers know how to supply this information.

There is no fairness in requiring employers and insurers to pay out thousands of dollars in fees without some kind of itemized billing or other similar justification for that fee. Nor is it fair to require hard working claimants' attorneys to accept less than they deserve due to the lack of documentation to support a fair award.

All the courts of this State, as well as many administrative agencies, have procedures designed to enable the parties to present the legal basis for an award and the relevant facts so that an appropriate award can be made in a manner by which the parties can understand the basis for the award. In my view, the fact that the Workers' Compensation Board has failed to adopt similar procedures puts us on shaky ground with regard to the confidence that the parties and the people of Oregon will have in this forum. We have the power and the duty to adopt rules of procedure that would resolve this problem. Until that occurs, I decline to try to guess at what an appropriate assessed attorney fee award should be when, as here, there is inadequate information to make an informed decision. For these reasons, I respectfully dissent.

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January 29, 1993 Cite as 45 Van Natta 139 (1993)

In the Matter of the Compensation of
**JAMES E. SMITH, Claimant**
WCB Case No. 92-00609
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant has requested reconsideration order of our December 30, 1992 Order on Review. Specifically, claimant contends that we erred in affirming an Order on Reconsideration that did not award permanent disability benefits for a right index injury.

In order to allow sufficient time to consider the motion, the above-noted order is abated and withdrawn. The SAIF Corporation is requested to file a response within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DARRELL W. VINSON, Claimant**
WCB Case Nos. 91-05363, 91-08114, 91-08115 & 91-04982
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Mitchell, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of Arbitrator Nichols' Order on Remand that: (1) set aside SAIF's denial of claimant's "new injury" claim for a low back condition; and (2) upheld Crawford and Company's (Crawford) denial of claimant's aggravation claim for the same condition. Claimant cross-requests review, contending that the attorney fee awarded on remand should be increased. On review, the issues are responsibility and attorney fees. We review the Arbitrator's decision for errors of law, ORS 656.307(2), affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

We affirm and adopt that portion of the Referee's order regarding this issue.

### Assessed Attorney Fee

The Arbitrator awarded claimant's attorney an assessed fee of $1,200 on the basis that he had actively and meaningfully participated in the proceeding. See ORS 656.307(5). Claimant contends that the Arbitrator's award should be increased to reflect the actual time devoted to the case both before and after the ".307" order issued, including representation, at hearing, an appeal to the Board, and a successful Order on Remand by the Hearings Division.

ORS 656.307(5) authorizes an insurer-paid attorney fee if claimant's counsel actively and meaningfully participates in the arbitration proceeding. ORS 656.307 contemplates a fee for all services reasonably rendered respecting the denials, including attorney fees for services rendered before the Department of Insurance and Finance issues an order designating a paying agent under ORS 656.307. Keenon v. Employers Overload, 114 Or App 344 (1992); Kenneth Cage, 43 Van Natta 1473 (1991); see also OAR 438-15-010(4)(a).

As a result of the Arbitrator's August 5, 1991 Arbitration Order and her June 19, 1992 Order on Remand, claimant's counsel has received an assessed attorney fee of $1,200. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we modify the Arbitrator's award. We conclude that a reasonable assessed fee for claimant's attorney's services for actively and meaningfully participating in the arbitration proceeding is $3,200. We particularly considered the time devoted to the case (as represented by the hearing record and statement of services), and the risk that claimant's counsel's services might go uncompensated.

Claimant also requests an attorney fee on review. A ".307" order issued prior to hearing and responsibility was the only issue litigated on review; therefore, claimant's compensation was not at risk of disallowance. Moreover, the record indicates that claimant's temporary disability rate is higher if Crawford is found responsible. (See Exs. 35 and 38). Therefore, claimant's right to compensation was not at risk of reduction had we reversed the Arbitrator's order. We, accordingly, conclude that claimant is not entitled to an insurer-paid attorney fee for services on review. ORS 656.382(2); Howard v. Willamette Poultry, 101 Or App 584 (1990); Riley E. Lott, Jr., 43 Van Natta 209 (1991).

## ORDER

The Referee's order dated June 19, 1992 is modified in part and affirmed in part. That portion of the order awarding claimant an assessed attorney fee is modified. In lieu of that award, claimant's attorney is awarded $3,200 for services rendered in actively and meaningfully participating in the arbitration proceeding, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**CAROL J. APPLEBEE, Claimant**
WCB Case No. 91-15845
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Menashe's order that: (1) set aside its "de facto" denial of claimant's right shoulder condition; and (2) found that claimant was entitled to temporary disability benefits. Claimant cross-requests review of that portion of the Referee's order that upheld SAIF's denial of her claim for right carpal tunnel syndrome. On review, the issues are compensability and temporary disability benefits.

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

Regardless of which physician is claimant's attending physician, SAIF did not request medical verification of claimant's inability to work as required by ORS 656.262(4)(b). Rather, SAIF merely informed claimant that Dr. Meyers was not qualified to be her attending physician and unilaterally terminated temporary disability benefits on that basis. Consequently, we agree with the Referee that SAIF did not comply with ORS 656.262(4)(b) and was not entitled to use that provision to terminate temporary disability benefits. See Doris F. Clothier, 44 Van Natta 978 (1992).

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 of her right shoulder condition and entitlement to temporary disability benefits is $1,000, to be paid by the SAIF Corporation. 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 June 4, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**GREG G. BROOKS, Claimant**
WCB Case No. 91-17887
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On December 18, 1992, we withdrew our November 23, 1992 order which reversed that portion of a Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent partial disability award at $305 per degree. We took this action to await the submission of the parties' proposed stipulation.

The parties have now submitted a proposed "Stipulation and Order," which is designed to resolve the rate of scheduled permanent disability issue. Specifically, the parties agree that claimant's scheduled permanent disability award shall be paid at a rate of $145 per degree unless and until there is an ultimate judicial determination in SAIF v. Herron, 114 Or App 64 (1992) providing that awards such as claimant's shall be paid at a rate of $305 per degree.

Parenthetically, we note that the Supreme Court has denied review in Herron. 315 Or 271 (1992). Thus, the condition precedent for the payment of claimant's award at a rate of $305 per degree will not materialize. Nevertheless, since our prior order was withdrawn for consideration of the parties' stipulation prior to the Supreme Court's decision, we have proceeded with our review of the agreement.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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February 2, 1993 Cite as 45 Van Natta 142 (1993)

In the Matter of the Compensation of
**FRANCISCA A. DURAN, Claimant**
WCB Case No. 91-07357
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Charles Lundeen (Saif), Defense Attorney

Claimant has requested reconsideration of our October 30, 1992 Order on Review. Pursuant to that request, we abated our order to allow the insurer an opportunity to respond. The insurer's response has been received.

Our original order found that claimant's symptoms were due to a degenerative low back condition. We further concluded that because the insurer had accepted only a back strain caused by a 1988 industrial injury, claimant's symptoms did not "result from the original injury" as is required by ORS 656.273(1). Therefore, we concluded that whether or not claimant's degenerative condition had worsened, she did not prove a compensable aggravation claim.

On reconsideration, claimant concedes that her current disability and need for medical treatment are the result of her degenerative condition. She asserts, however, that her aggravation claim is compensable because she has proven that her industrial injury was the major contributing cause of a worsening of her degenerative condition.

A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be found compensable. We determine whether the worker's current condition is compensable, and if it is, whether that condition has worsened. See Bertha M. Gray, 44 Van Natta 810 (1992).

Claimant's degenerative condition preexisted her industrial injury. She asserts that the injury combined with and, thereby, worsened the preexisting condition, resulting in her current symptoms. ORS 656.005(7)(a)(B) is, therefore, applicable. Under this statute, claimant must prove that her compensable injury, rather than the preexisting condition, is and remains the major contributing cause of her disability or need for treatment. See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

For the reasons cited in our original order, we continue to find the reports of Drs. Neufeld and Wilson unpersuasive. We also remain persuaded from the reports of Drs. Poulson, Fuller and Andersen, that claimant's symptoms are attributable solely to her degenerative condition. Claimant, however, contends that the industrial injury caused the preexisting condition to degenerate at a faster rate, thereby resulting in a more disabling condition. (Ex. 136-3, -4). She relies on the reports of Dr. Poulson for this proposition.

As previously noted, ORS 656.005(7)(a)(B) provides that a condition resulting from the combination of a compensable injury and a preexisting condition is compensable only where the compensable injury is and remains the major contributing cause of the disability or need for treatment. We interpret this statute to mean that it is not sufficient that the compensable injury causes an acceleration of the progression of a preexisting condition; rather, the compensable injury itself must be the major contributing cause of the disability and need for treatment. See Tektronix, Inc. v. Nazari, supra.

Dr. Poulson opines that claimant's compensable injury has indirectly caused a need for treatment by increasing the rate of degeneration. Thus, it is the degenerative condition rather than the compensable injury that is now causing claimant's symptoms. Further, there is no evidence that the compensable injury made claimant's degenerative condition become symptomatic. (See Ex. 133-1, -2). Thus, we conclude that claimant has not proven that her current condition is compensable under ORS 656.005(7)(a)(B). We, therefore, need not reach the remaining issue of whether claimant's compensable condition has worsened.

On reconsideration, as supplemented herein, we adhere to and republish our October 30, 1992 order except for those portions not consistent with this order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEORGE E. EKERSON, Claimant**
WCB Case No. 91-14507
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Westerband and Brazeau.

The SAIF Corporation requests review of that portion of Referee Thye's order that directed it to pay claimant's scheduled permanent disability awards at the rate of $305 per degree. Claimant cross-requests review of those portions of the order that: (1) increased claimant's scheduled permanent partial disability award for a right forearm (wrist) condition from 24 percent (36 degrees), as awarded by an Order on Reconsideration, to 28 percent (42 degrees); (2) increased claimant's scheduled permanent partial disability award for a left forearm (wrist) condition from 24 percent (36 degrees), as awarded by an Order on Reconsideration, to 32 percent (48 degrees); and (3) declined to award penalties and attorney fees for SAIF's failure to pay the awards at the rate of $305 per degree. On review, the issues are extent of scheduled permanent disability, rate of scheduled permanent disability and penalties. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the second sentence of the "Findings of Ultimate Fact."

## CONCLUSIONS OF LAW AND OPINION

### Extent of scheduled permanent disability

We adopt the Referee's "Conclusions and Opinion" concerning this issue, with the following exception and supplementation.

Claimant contends that he is entitled to impairment ratings for bilateral loss of forearm (wrist) strength, as evidenced by Dr. Nolan's grip and pinch strength measurements, and for loss of supination in his elbows. We disagree.

The Referee declined to rate the loss of grip and pinch strength reported by Dr. Nolan, consulting physician, in part because the medical evidence does not identify the nerve supplying the muscles affected by the reported loss, citing OAR 436-35-110(2). The rule provides: "Loss of strength due to loss of muscle or disruption of the musculotendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired." (Emphasis added). Considering the emphasized portion of the rule, we conclude that where the evidence indicates that loss of strength is due to loss or disruption of muscle, the nerve presumed (under the rule) to be affected need not be identified. Accordingly, we do not adopt that portion of the Referee's opinion, in the second full paragraph on page 4, which is based on the lack of evidence identifying nerve injury.

However, we nonetheless agree with the Referee's conclusion that claimant is not entitled to ratings for loss of strength because Dr. Button, treating physician, specifically disagreed (see Exs. 31-14-16, 31-23, 31-40-43) with the strength measurements reported by Dr. Nolan, consulting physician (see Exs. 26B-5-8, 26B-12-14). Inasmuch as Button did not concur with Nolan's strength measurements, those measurements may not be used to determine claimant's impairment. See OAR 436-35-007(8). Alex I. Como, 44 Van Natta 221 (1992); Dennis E. Connor, 43 Van Natta 2799 (1991).

In addition, claimant asserts entitlement to an impairment rating for loss of elbow supination, based on Nolan's measurement's in that regard. (See Ex. 26B-4). However, based on Button's comment that claimant's wrist surgery did not impact elbow supination (see Ex. 31-33) and the absence of evidence that claimant's compensable wrist condition involved his elbows, we conclude that Button did not concur with Nolan's measurement of lost supination. Accordingly, claimant has not proven entitlement to a rating on this basis. See OAR 436-35-007(8).

Inasmuch as claimant challenged only the Referee's impairment ratings and we agree with those ratings, we do not disturb claimant's scheduled permanent disability award.

Rate of scheduled permanent disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Penalty

Inasmuch as claimant was not entitled to the $305 per degree rate of compensation, SAIF's failure to pay at that rate was not unreasonable. Accordingly, claimant is not entitled to a penalty on this basis.

ORDER

The Referee's order dated March 3, 1992 is reversed in part and affirmed in part. That portion of the order which directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree and an attorney fee payable from this increased compensation are reversed. The remainder of the order, including the out-of-compensation attorney fee payable from claimant's increased permanent disability awards, is affirmed.

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In the Matter of the Compensation of
**NOEMITH GIRON, Claimant**
WCB Case No. 91-12372
ORDER ON RECONSIDERATION
Michael B. Dye, P.C., Claimant Attorneys
Schultz & Taylor, Defense Attorneys

On January 22, 1993, we affirmed a Referee's order that awarded claimant 36 percent (115.2 degrees) unscheduled permanent disability for a thoracolumbar condition. In reaching our conclusion, we agreed with the Referee's decision not to consider a "post-reconsideration order" deposition from a medical arbiter. On further reflection, we retract that portion of our order because, as we alternatively found, consideration of the deposition would not have altered our decision. Consequently, we express

no opinion concerning whether a "post-reconsideration order" medical arbiter deposition can be considered under ORS 656.268(7).

Accordingly, we withdraw our January 22, 1993 order. On reconsideration, as supplemented and modified herein, we republish our January 22, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEORGE GODDARD, Deceased, Claimant**
WCB Case No. 91-04998
ORDER ON REVIEW
Royce, Swanson & Thomas, Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Hazelett's order that assessed a 10 percent penalty on medical bills which remained unpaid on the date of claim acceptance. On review, the issue is penalties. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

In his original order, the Referee found the insurer's denial and its delay in paying compensation to be unreasonable, but concluded that a penalty could not be assessed on medical bills pending acceptance or denial of the claim. On reconsideration, the Referee relied on our decision in Kim S. Jeffries, 44 Van Natta 824 (1992), to assess a penalty on medical bills which remained unpaid at the time of claim acceptance, but which had been paid prior to hearing.

On review, the insurer argues that a penalty may not be based on medical bills which were unpaid at the time of claim acceptance. It contends that the medical bills at issue were not payable until acceptance and its actions here were not unreasonable, because it paid the medical bills within 3 days of acceptance of the claim.

We conclude that Jeffries is distinguishable from the present case. In Jeffries, we set aside the insurer's denial and assessed a penalty based on all compensation, including medical services, due at the time of the hearing. We reasoned that when the penalty is assessed at the time of the hearing, when a denial is set aside by the Board, all expenses incurred by claimant for medical services and all time loss become amounts then due.

Here, by contrast, the claim was accepted prior to hearing and no medical bills remained unpaid on the date of hearing. As a consequence, the medical bills were not amounts then due upon which a penalty could be based at the time of the hearing. Rather, they were amounts which became payable upon acceptance of the claim. The insurer reasonably paid the bills promptly upon acceptance. Accordingly, the Referee's award of a 10 percent penalty based on medical bills due at the time of claim acceptance is reversed.

However, an attorney fee may be awarded under ORS 656.382(1) when an insurer 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. Here, we agree with the Referee that the insurer's conduct constituted unreasonable resistance to the payment of compensation. Although the insurer had determined after its investigation that the claim was compensable by December 4, 1990, it

did not formally accept the claim until June 28, 1991. The insurer offered no reasonable explanation for its failure to respond to the claim. Furthermore, its conduct resulted in a delay in payment of benefits which were compensable. This delay is especially unreasonable in light of the fact that the insurer's unreasonable conduct continued even after any possible legitimate doubt about the compensability of the claim had been eliminated.

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 concerning the unreasonable denial is $1,000.

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 April 14, 1992, as reconsidered June 5, 1992, is reversed in part and affirmed in part. That portion of the Referee's order that assessed a 10 percent penalty on the medical bills which were unpaid on the date of acceptance is reversed. Claimant's attorney is awarded $1,000 as a fee for services related to the unreasonable denial and delay of payment of compensation. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**DEBRA L. PAWLOWSKI, Claimant**
WCB Case No. 91-17875
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Roberts, et al., 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 claim for a current neck, shoulder, back and headache condition. On review, the issues are res judicata and, if the denial is not precluded, compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for her "Findings of Ultimate Fact, with the following modification.

The Referee found that, in August 1991, claimant resumed treatments for conditions identical to those previously deemed compensable. Instead, we find that claimant's condition at the time of the February 18, 1992 denial was not the same as her condition at the time of the unappealed March 1, 1991 Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The doctrine of res judicata, specifically issue preclusion, will prevent the employer from denying claimant's current condition if the condition currently claimed and denied is the same as the condition previously claimed, actually litigated and finally determined to be compensable. See North Clackamas School Dist. v. White, 305 Or 28, 53, modified 305 Or 468 (1988). Accordingly, we first consider whether claimant's current condition is the same as it was when the prior Referee's order issued on March 1, 1991.

Claimant's current symptoms are similar to her previous complaints. We conclude however, that claimant's current condition is not the condition previously litigated.

The prior claim involved bilateral hand, wrist, forearm, shoulder, and neck tendonitis or overuse syndrome conditions. The claim was closed by a March 15, 1991 Notice of Closure which did not award claimant any permanent disability. That claim closure was not appealed, and therefore, became final by operation of law. Following that claim closure, claimant did not seek medical treatment for almost a

year (specifically, from October 16, 1990 to August 9, 1991). Drs. Ronald Lohman and Gerald Reimer opine, without contradiction in this record, that claimant's current symptomology did not have any physical basis, was unrelated to claimant's work, and that a psychiatric examination was recommended. Thus, the evidence preponderates in favor of the conclusion that claimant's current condition is not causally related to her work with the employer and that, unlike the conditions previously found compensable, claimant's current condition has no physical basis. In other words, any condition claimant now has is a new condition unrelated to her work with the employer or the conditions previously found compensable. Therefore, issue preclusion does not operate to bar the employer's current condition denial.

Compensability

The employer issued a "current condition" denial on October 26, 1990, contending that there are no objective findings supporting claimant's complaints and that her current symptoms are unrelated to her work exposure with the employer.

The medical evidence concerning the causation of claimant's current condition comes from Dr. Balmer, current treating physician, and Orthopaedic Consultants, independent examiners. Balmer reported that claimant sought treatment in October 1991 "on a long term work injury claim," and stated that claimant would attempt to provide him with prior treatment records "for this problem." (Ex. 32-1-2). However, there is no subsequent opinion from Balmer indicating that he obtained and reviewed claimant's prior records. Without the benefit of a complete medical history, Balmer suspected "chronic pain syndrome which the patient blames on old trauma. There are features of myofascial pain syndrome which may be the result of old injuries." (Ex. 32-2). Considering the speculative nature of Balmer's conclusion and his apparent lack of a complete history, we do not find his opinion to be particularly persuasive.

The Consultants, on the other hand, examined claimant on January 23, 1992 and reviewed her treatment history, beginning with the August 1, 1990 compensable injury. (See Ex. 34). Based on a normal physical examination and the absence of objective signs of impairment, the Consultants concluded that claimant's subjective complaints far outweigh any objective findings and concluded that claimant's work exposure with the employer was not "in any way responsible for her current complaints." (Ex. 34-7). Based on the Consultant's well-reasoned opinion, which is based on an accurate history, we conclude that claimant has not established that her current conditions are work-related. Accordingly, the employer's denial is reinstated and upheld.

ORDER

The Referee's order dated May 11, 1992 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's $1,600 assessed attorney fee award is reversed.

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February 3, 1993 Cite as 45 Van Natta 147 (1993)

In the Matter of the Compensation of
**JANICE I. ANDERSON, Claimant**
WCB Case No. 91-07397
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of that portion of Referee Hazelett's order which affirmed a Director's Determination Order that declined to reclassify claimant's right knee injury claim from nondisabling to disabling. On review, the issue is reclassification. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the third and fourth paragraphs, with the following supplementation.

On September 27, 1990, Dr. Puziss, claimant's treating physician, examined her. He restricted her to work which did not involve repetitive squatting.

After her injury, claimant tried to continue her regular job as a bartender. However, it was impossible for claimant to perform her bartender duties without repetitive squatting.

Claimant was laid off at the end of September 1990. She has not worked since then.

Claimant has chronic chondromalacia of the right patella as a result of her industrial injury which limits repetitive use of her right knee.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to establish that she lost wages due to her injury or that she would be entitled to permanent disability once medically stationary. Consequently, he concluded that claimant was not entitled to have her claim reclassified as disabling. We disagree.

In order to be entitled to reclassification of her claim from nondisabling to disabling within a year after her injury claimant, who is not medically stationary, must establish either that: (1) as a result of the injury, temporary disability benefits are payable; or (2) when medically stationary, it is likely claimant will be entitled to an award of permanent disability under the standards. See former OAR 436-30-045. In regard to temporary disability benefits, claimant is entitled to payment of benefits for temporary disability if the preponderance of the evidence indicates that she was disabled during the relevant period. See Botefur v. City of Creswell, 84 Or App 627 (1987).

Following her August 4, 1990 right knee injury, claimant was treated at the hospital, where the examining physician diagnosed "right knee contusion" and released her to modified work. (Ex. 2). Claimant testified that she was "off" several days after the injury and had problems doing her job when she returned to work because her knee would swell. (Tr. 20). Dr. Puziss, who subsequently became claimant's treating physician, examined her on September 27, 1990. While he did not specifically address whether claimant was released to regular or modified work, he noted that she was not "stationary" and restricted her to work which did not involve repetitive squatting. (Ex. 3A).

Claimant testified that she returned to her bartending job, but found it impossible to do her regular job as a bartender without repetitive squatting. (Tr. 20-21). She was laid off for reasons unrelated to her injury in late September 1990 and has not worked since. (Tr. 18, 21). Additionally, Dr. Puziss subsequently stated in a December 6, 1990 letter to the SAIF Corporation that claimant now had an antalgic gait and continued to have right knee pain and synovitis. (Ex. 3D). He predicted that too much walking would cause claimant's knee to swell. (Id). Dr. Puziss also noted that claimant was still not "stationary" and should continue to avoid squatting. (Id). On this record, we find that claimant has been at least partially disabled since her August 4, 1990 industrial injury.

Furthermore, we also find that it is likely that claimant will be entitled to an award for permanent disability under the standards when she becomes medically stationary. In this regard, Dr. Marble, who performed an independent medical examination, diagnosed chondromalacia of the patella. (Ex. 8-5). He stated that claimant would not be able to return to her work as a bartender and opined that "[t]his patient has a chronic problem that, in my judgment, will have some degree of permanence." (Ex. 8-6, 8-7). Dr. Puziss concurred with this opinion on September 12, 1991. (Ex. 10).

OAR 436-35-010(6)(b) provides for a 5 percent award for a chronic condition limiting repetitive use of claimant's right knee. Therefore, based on this medical evidence coupled with claimant's testimony that her right knee problems have worsened since her injury (Tr. 22), we find that it is likely claimant will be entitled to an award of permanent disability under the standards when she is medically stationary.

Accordingly, we conclude on this evidence that claimant has established that she is entitled to reclassification of her right knee injury claim from nondisabling to disabling. See former OAR 436-30-045.

ORDER

The Referee's order dated February 26, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which affirmed the December 17, 1990 Determination Order that declined to reclassify claimant's claim from nondisabling to disabling is reversed. The Determination Order is set aside, the classification of claimant's right knee injury claim shall be changed to disabling and benefits paid accordingly. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**DEBRA J. KENTTA, Claimant**
WCB Case No. 91-13897
ORDER ON RECONSIDERATION
Ronald Fontana, Claimant Attorney
Mitchell, et al., Defense Attorneys

Claimant requests reconsideration of our January 13, 1993 Order on Review that: (1) affirmed the Referee's order that upheld the self-insured employer's denial to the extent that it denied claimant's condition after an off-work motor vehicle accident; (2) affirmed that portion of the Referee's order that awarded a penalty for an allegedly unreasonable denial of payment for a doctor's examination, but reversed that portion of the Referee's order that awarded an assessed attorney fee in relation to that denial; and (3) reversed that portion of the Referee's order that awarded an assessed attorney fee for an allegedly improper denial of claimant's condition. The employer has filed its response to claimant's motion. We grant the motion for reconsideration.

Claimant first contends on reconsideration that the employer not only denied payment of claimant's July 9, 1991 treatment by Dr. Rath, but that it also denied claimant's condition even before the July 9, 1991 motor vehicle accident. Claimant contends that she is entitled to the assessed attorney fee awarded by the Referee for prevailing on the denial of her pre-accident condition. In essence, claimant contends that the employer orally denied two separate claims and that she has prevailed on both claims.

We agree on reconsideration that claimant is entitled to the assessed fee awarded on this issue by the Referee, but we reach this conclusion based on the following reasoning. First, we disagree with claimant's contention that the employer separately denied claimant's condition as it existed before the motor vehicle accident. Although the colloquy among counsel and the Referee is confusing, it is apparent that the employer was arguing two separate grounds for upholding its denial of Dr. Rath's July 9, 1991 treatment. The first ground was that claimant did not, in fact, treat with Dr. Rath on July 9, 1991. The second ground was that any such treatment was not causally related to the compensable injury because that injury had resolved. Accordingly, claimant is entitled to a single assessed fee for prevailing on the denial of payment for Dr. Rath's July 9, 1991 treatment.

However, in our order, we mistakenly concluded that the Referee's attorney fee award was a penalty-related assessed fee under ORS 656.382(1). Because claimant was entitled to a penalty for the unreasonableness of its denial under ORS 656.262(10), we reversed the award of a separate assessed fee. See Nicolosa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). On reconsideration, we conclude that the Referee's assessed fee was not intended as a penalty-related fee under ORS 656.382(1), but rather was intended as an ORS 656.386(1) fee for prevailing over the medical services denial. Therefore, the Referee's $500 assessed fee for prevailing on the medical services denial was entirely proper and we reinstate the fee.

Claimant also contends on reconsideration that we erred in concluding that the employer's denial was not an impermissible prospective or preclosure denial. On reconsideration, we have nothing to add to our prior discussion of this issue. Therefore, we continue to adhere to our conclusion that the denial of claimant's post-motor vehicle accident condition was not improper and, therefore, the Referee's penalty-related fee on this issue is reversed.

Accordingly, we withdraw our January 13, 1992 order. On reconsideration, as amended and supplemented herein, we adhere to and republish our prior order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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February 4, 1993 Cite as 45 Van Natta 150 (1993)

In the Matter of the Compensation of
**MICHELLE K. DIBRITO, Claimant**
WCB Case No. 91-13969
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's stress claim. In its brief, SAIF also objects to the Referee's exclusion of numerous exhibits. On review, the issues are compensability and evidence. We reverse.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt his Ultimate Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee found this claim to be a compensable industrial injury. We conclude that the claim is one for a stress-caused physical condition, which must fall within ORS 656.802(1)(b) in order to be compensable.

Here, claimant became upset during a May 14, 1991 meeting at work in which she was told she would not be able to retain her full-time employee status if her request to work part-time was granted. She experienced physical symptoms which caused disability and required treatment. Dr. Marx, M.D., claimant's treating physician, opined that the stress of the meeting made her preexisting colitis condition symptomatic.

On review, claimant contends that the May 14, 1991 incident was an injury because it was sudden in onset. To support her contention, claimant cites to the Board cases of Shawn M. Hukari, 42 Van Natta 2687 (1990) and Jerry B. Mathel, 44 Van Natta 1113 (1992). In Hukari, we concluded that the claimant's flare-up of her intestinal condition, which was caused by stress, should be analyzed as an injury because it took place within a discrete period of work activity and was sudden in onset.

However, subsequent to the Referee's order here, the court reversed our opinion in Hukari, supra, and concluded that a preexisting physical disease that is exacerbated by stress at work and results in disability or a need for medical treatment must be treated as an occupational disease under ORS 656.802. SAIF v. Hukari, 113 Or App 475 (1992). Based upon the court's decision in Hukari, we reversed our conclusion in Mathel, supra, and found that the claimant's infarction claim was not compensable. Mathel, 44 Van Natta 1113 (1992), on recon 44 Van Natta 1532 (1992). Therefore, in the present case, we conclude that claimant's condition must be analyzed pursuant to ORS 656.802.

In analyzing claimant's claim under ORS 656.802, we agree with the Referee's reasoning that, as the only psychiatrist to examine claimant, Dr. Thompson has provided the most persuasive opinion in regard to her psychological condition. Dr. Thompson diagnosed claimant as having a preexisting personality disorder, which was unaffected by the stress at work. (Ex. 45-11). Dr. Thompson stated that the primary cause or major contributing cause of claimant's personality disorder, which he diagnosed in August 1991, was claimant's relationship with her mother and her inability to resolve her feelings after her mother died. (Ex. 45-25).

Under the circumstances, because claimant's psychological condition was due, in major part, to factors other than work conditions, we conclude that claimant has failed to establish by clear and convincing evidence that her psychological condition arose out of and in the course of her employment. 656.802(3). Accordingly, we conclude that claimant has not proven a compensable psychological condition pursuant to ORS 656.802, and neither claimant's mental condition nor her physical symptoms resulting from on-the-job stress are compensable. Consequently, we reverse the Referee's order on the issue of compensability. The Referee's attorney fee award is also reversed.

Evidence

The Referee excluded several exhibits submitted by SAIF, on the ground that the documents consisted of hearsay. On review, SAIF argues that the exhibits should have been admitted as they possess an indicia of reliability because they bear a state letterhead or the signature of the author, or because they are business records.

The exhibits were offered to prove that claimant misperceived certain events or that factors contributing to her stress were not "real and objective." However, we have concluded that claimant's psychological condition is not compensable because the major cause of her personality disorder was her relationship with her mother and her unresolved feelings after her mother died. Accordingly, we conclude that it is unnecessary to consider SAIF's proffered evidence regarding claimant's concerns about the safety of the work environment.

ORDER

The Referee's order dated April 13, 1992 is reversed. The SAIF Corporation's denial of July 30, 1991 is reinstated and upheld. The Referee's attorney fee award of $6,000 is also reversed.

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In the Matter of the Compensation of
**DAVID R. SILLS, Claimant**
WCB Case No. 89-00394
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Mongrain's order that set aside its denial of claimant's occupational disease claim for a toxic exposure. 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 affirm the Referee's "Opinion," with the following supplementation.

On review, SAIF contends that the Referee should not have relied upon the opinion of Dr. Buscher, an environmental medicine specialist. SAIF argues that Dr. Pocekay and Dr. O'Malley found no connection between claimant's hepatitis and his exposure to pentachlorophenol (PCP). Drs. Pocekay and O'Malley reported that, although the chemical lindane caused hepatitis in animals, claimant did not have direct contact with the chemical. Dr. Wagner, a professor of toxicology, also reported that, to his knowledge, lindane was not an issue in claimant's illness. SAIF argues that Dr. Buscher had an inaccurate history of claimant's exposure to the chemical. We disagree.

Claimant's Form 801 and the accompanying medical report establish that he was exposed to the chemical Ambrocide, which contained lindane. (Ex. 2, 3). The report stated that claimant was exposed to several substances, including Ambrocide, between December 1985 and 1986, because the pump he was using did not work properly and he had repeated contact with the full strength solution, in addition to inhaling dust around the dip tank. (Ex. 3-1). Claimant also testified to his exposure to such chemicals. Accordingly, we do not find Dr. Buscher's report to be inaccurate. Moreover, we conclude that, because the other doctors believed that claimant did not have direct contact with lindane, their opinions are based upon misinformation and are less persuasive for that reason.

SAIF also argues that Dr. Buscher's opinion is not persuasive because he mistakenly believes that industrial PCP contains the most toxic form of dioxin (TCDD). Dr. Wagner reported that TCDD is not a factor in PCP exposure cases. However, Dr. Buscher addressed the issue in his report which concluded that Dr. Wagner's approach had been supported in reference material up to 1976, but not any longer. Dr. Buscher also attached four recent studies to support his conclusion. (Ex. 15-5).

Finally, SAIF contends that Dr. Buscher is not persuasive because he found that claimant suffered from toxic chemical liver damage despite the fact that no chloracne was noted. Dr. Buscher addressed the issue in his rebuttal report, however, when he stated that, although a common symptom, chloracne was not experienced in all PCP exposures. (Ex. 17).

We agree with claimant that the Referee properly weighed the medical opinions and, in this case, found that the opinion of Dr. Buscher was most persuasive. We conclude that Dr. Buscher's opinion is complete, well-reasoned, and satisfactorily rebuts the issues raised by the other medical opinions. Accordingly, we affirm the Referee on the issue of compensability.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for review on the issue of compensability. 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 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 April 10, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $900, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**JEAN M. BATES, Claimant**
WCB Case No. 91-15750
ORDER ON REVIEW
Claudette Yost, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brown's order that: (1) declined to award temporary disability benefits; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Most of our findings are drawn from Exhibit 4, which is a copy of the Board's Order on Review. Jean M. Bates, 43 Van Natta 2280 (1991), aff mem Digger O'Dells Steakhouse v. Bates, 115 Or App 757 (1992). Claimant left work, due to her mental stress condition, on May 11, 1989. The next day, Dr. Bates, family physician, released claimant from work for four weeks, due to her emotional condition. On May 18, 1989, claimant filed a claim for mental stress, which the insurer denied on May 25, 1989.

On June 12, 1989, claimant briefly returned to work. However, she did not work for the employer after June 23, 1989. On June 27, 1989, Dr. Gardner, independent medical examiner, diagnosed "Adjustment Disorder with Mixed Emotional Features." Dr. Dixon, attending psychiatrist, agreed with Gardner's diagnosis and found that claimant was unable to work.

On July 11, 1989, claimant filed another claim for mental stress, which the insurer denied on July 24, 1989. On July 25, 1989, Dr. Dixon released claimant from working.

Claimant requested a hearing, which was held on October 19, 1989 and April 17, 1990. The Referee upheld the insurer's denials of claimant's occupational disease claim for a mental disorder. On October 8, 1991, the Board reversed the Referee's order. Jean M. Bates, supra. The insurer was directed to process claimant's claim in accordance with law. On November 4, 1991, the insurer requested judicial review of the Board's order.

On November 5, 1991, Dr. Dixon issued an evaluation report concerning claimant's potential return to work. (Exhibit 5). Diagnosing post-traumatic stress syndrome, Dixon agreed that a proposal for a nine month cognitive therapy treatment would be appropriate. Nevertheless, noting that claimant was 5 weeks from giving birth, Dixon suggested delaying the treatment until "a month or two after the birth of this baby." Without the complication of the new baby, Dr. Dixon concluded that claimant would be ready for full-time employment within 9 to 12 months. However, Dr. Dixon further stated that claimant would probably not return to full-time work until her baby was 2 to 3 years old.

During the pendency of its appeal of the Board's compensability decision, the insurer has not paid temporary disability to claimant. On October 14, 1992, the Court of Appeals affirmed the Board's compensability order without opinion. Digger O'Dells Steakhouse v. Bates, supra.

## CONCLUSIONS OF LAW AND OPINION

### Temporary disability

The Referee found that claimant was not entitled to temporary disability as a result of the Board's order because Dr. Dixon had concluded that claimant was unable to work due to her pregnancy. Reasoning that there was no time loss authorization, the Referee declined to award temporary disability. We disagree.

The filing of an appeal by a carrier stays payment of the compensation appealed, except for 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. ORS 656.313(1)(a)(A); Walden J. Beebe, 43 Van Natta 2352 (1991).

Here, the insurer timely petitioned the court for review of the Board's compensability decision. Consequently, all temporary disability benefits accruing prior to the Board's October 8, 1991 decision could be stayed. However, such benefits accruing after that date could not be stayed. Thus, the insurer was obligated to provide those benefits unless claimant was never entitled to such compensation or the insurer was authorized to terminate such compensation under ORS 656.268.

To receive temporary disability, a claimant must be in the work force at the time of her disability. A worker who has voluntarily withdrawn from the work force is not entitled to such compensation. Cutright v. Weyerhaeuser, 299 Or 290 (1985).

The critical time for determining whether claimant has withdrawn from the work force is at the time of her disability. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). Entitlement to temporary disability benefits is not dependent on whether a claimant has retired or withdrawn from the work force if the claimant's disability arose before the claimant's withdrawal from the work force. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990).

Here, claimant left work in 1989 as a result of her compensable psychological condition. Moreover, as noted by her attending psychiatrist (Dr. Dixon), she was unable to return to work at that time. Inasmuch as she was in the work force at the time of her disability, claimant is entitled to "post-October 8, 1991" temporary disability (compensation which is not stayed under ORS 656.313(1)(a)(A)) barring the occurrence of the one of the events set forth in ORS 656.268(3).

Pursuant to ORS 656.268(3), temporary disability payments 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. See Soledad Flores, 43 Van Natta 2504 (1991).

There is no contention that, following the Board's October 8, 1991 order, claimant had returned to any kind of employment. Furthermore, no assertion is made that Dr. Dixon had released claimant to modified employment and the employer had offered such employment to claimant. Thus, subsections (a) and (c) of ORS 656.268(3) have not been satisfied.

In essence, the insurer is arguing that Dr. Dixon effectively released claimant to return to regular work because claimant's current disability was attributable to her pregnancy. We disagree with this proposition for several reasons.

To begin, Dr. Dixon does not expressly release claimant to any kind of employment. To the contrary, Dr. Dixon reports that claimant will need extensive therapy to prepare her for a future return to work. Moreover, despite Dr. Dixon's prediction that claimant would not return to work for several years because of the impending birth of her child, Dr. Dixon also concluded that irrespective of the pregnancy, claimant would require therapy and would not be ready for full-time employment for 9 to 12 months.

In light of such circumstances, we find that none of the requisite events set forth in ORS 656.268(3) which would permit the insurer to terminate claimant's temporary disability at the time of the Board's October 8, 1991 order had occurred. Consequently, we hold that claimant is entitled to temporary disability benefits from October 8, 1991 until such benefits can be lawfully terminated.

In reaching this conclusion, we wish to emphasize that our decision is confined to claimant's procedural entitlement to temporary disability. To the extent that the insurer contends that claimant's pregnancy constitutes a withdrawal from the work force which effects her substantive entitlement to temporary disability, that is an argument which would be ripe for determination at the time of claim closure. See Galvin C. Yoakum, 44 Van Natta 2403 (1992) on recon 44 Van Natta 2492 (1992); Esther C. Albertson, 44 Van Natta 521, 522-23 (1992).

Penalties and Attorney Fees

Claimant requests penalties and attorney fees under ORS 656.262(10), based on the insurer's allegedly unreasonable refusal to pay claimant's temporary disability compensation.

The insurer's refusal to pay is not unreasonable if it has a legitimate doubt about its liability. Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990). In this case, the insurer argues that claimant is not entitled to temporary disability benefits, because she was not working after October 8, 1991 for reasons other than the compensable condition. Although this defense may be relevant to claimant's substantive entitlement to temporary disability benefits, as we have stated, it is not relevant to claimant's procedural entitlement to temporary disability benefits under this open claim. Moreover, in light of the plain language of ORS 656.268(3), we conclude that the insurer's failure to pay temporary disability compensation was unreasonable. See Esther C. Albertson, supra. Accordingly, a penalty is assessed, 50 percent of which will be paid to claimant's counsel in lieu of an attorney fee. ORS 656.262(10)(a).

ORDER

The Referee's order dated January 28, 1992, as reconsidered April 27, 1992, is reversed. The insurer is directed to pay claimant temporary disability compensation from October 8, 1991 until such benefits can be lawfully terminated. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800. In addition, claimant is awarded a penalty of 25 percent of the compensation due under this order. One-half of this penalty shall be paid to claimant's attorney in lieu of a penalty-related attorney fee.

In the Matter of the Compensation of
**MICHAEL E. COONEY, Claimant**
WCB Case No. 91-12106
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Cliamant requests review of those portions of Referee Bethlahmy's order that: (1) denied his request that the issue of the extent of scheduled permanent disability be remanded to the Director for adoption of temporary rules amending the standards; and (2) declined to assess a penalty or related attorney fee for the insurer's allegedly unreasonable failure to pay claimant's award of scheduled permanent disability at the rate of $305 per degree. In its brief, the self-insured employer cross-requests review contending that the Referee erred in calculating the amount of claimant's award of scheduled permanent disability. On review, the issues are authority of the Hearings Division and the Board to remand an order on reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C), penalties and calculation 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

### Adoption of Temporary Rule

Claimant contends that this matter should be remanded to the Director for adoption of a rule concerning chondromalacia. We disagree.

Subsequent to the Referee's order, we issued our decision in Gary D. Gallino, 44 Van Natta 2506 (1992). In Gallino, we held that neither the Hearings Division or the Board has the authority authority to remand a case to the Director for a finding that claimant's disability is not addressed by the standards and for the adoption of temporary rules to accommodate such impairment. Id. We reasoned that ORS 656.726(3)(f)(C) invests the Director with exclusive authority to enact standards for determining disability.

Therefore, the Referee correctly declined to remand this matter to the Director for adoption of a rule addressing claimant's chondromalacia. Gallino, supra.

### Penalties

We adopt the Referee's conclusions and reasoning concerning the penalty issue with the following comment.

We agree with the Referee's reliance on our decisions in Mary E. Weaver, 43 Van Natta 2618 (1991) and John Keller, 38 Van Natta 1351 (1986). In addition, we note that subsequent to the Referee's order the Court of Appeals reversed our decision in Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991). See SAIF v. Herron, 114 Or App 64 (1992), rev den 315 Or 271 (1992).

### Calculation of Extent of Permanent Disability

The Referee increased claimant's award of scheduled permanent disability for loss of use or function of the left leg from 31 percent, as awarded by an Order on Reconsideration, to 34 percent. The employer does not contest the values used by the Referee to determine claimant's extent of disability. However, the employer submits that the Referee erred in calculating those values and contends that claimant's award should be 33 percent. We agree.

Claimant is entitled to 11 percent for retained flexion of the knee; 1 percent for loss of extension; 10 percent for joint instability of the medial collateral ligament; 5 percent for a partial medial meniscectomy; 5 percent for a partial lateral meniscectomy; and, 5 percent for a chronic condition limiting repetitive use of the left knee.

Pursuant to OAR 436-35-220(4) and OAR 436-35-240(1) the impairment values are combined for a total award of 33 percent. Therefore, we modify the Referee's order to award claimant a total of 33 percent scheduled permanent disability for the left leg (knee).

Finally, as noted above, we have no authority to remand case to the Director for the adoption of temporary rules where the standards fail to provide for certain impairment. Nevertheless, since the Director has subsequently promulgated a rule providing for an impairment award for chondromalacia, we can apply that rule. Gary D. Gallino, supra.[1]

Here, Dr. Neitling reported that claimant had chondromalacia in the patellofemoral and medical compartments and rated the severity as a 16 or 17 on a scale of 20. However, under the Director's temporary rule (OAR 436-35-230(13)(a)-(b)), an award is available only where an injured worker has grade IV chondromalacia, secondary strength loss, chronic effusion or varus or valgus deformity. There is no evidence that claimant has chronic effusion, secondary strength loss or a varus or valgus deformity. Moreover, although Dr. Neitling indicates that claimant has severe chondromalacia, Dr. Neitling does not state that it is grade IV. Inasmuch as Dr. Neitling's report is not in conformance with the requirements of OAR 436-35-230(13)(a)-(b), his report is not persuasive evidence. See Ronald E. Ingram, 44 Van Natta 313 (1992); Lawrence E. Wilson, 43 Van Natta 1131 (1991). Accordingly, claimant has not established that he is entitled to an impairment award pursuant to OAR 436-35-230(13)(a)-(b).

ORDER

The Referee's order dated January 6, 1992 is modified in part and affirmed in part. In lieu of the Referee's award of of scheduled permanent disability and in addition to the 31 percent awarded by the Order on Reconsideration, claimant is awarded 2 percent (3 degrees) for a total of 33 percent (49.5 degrees) scheduled permanent disability for his left leg injury. The remainder of the Referee's order is affirmed.

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[1] Although a signatory to this agreement Board Member Gunn directs the parties to his dissent in Gallino, supra.

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In the Matter of the Compensation of
**DONALD S. JAMES, Claimant**
WCB Case No. 92-11898
ORDER OF DISMISSAL
Schwabe, et al., Defense Attorneys

Claimant, pro se, has requested Board review of Referee Podnar's December 22, 1992 order. The insurer has moved for dismissal of claimant's request for review on the basis that the request was untimely. We agree and dismiss.

FINDINGS OF FACT

On December 22, 1992, the Referee issued his Opinion and Order. On January 25, 1993, the Board received claimant's request for Board review of the Referee's December 22, 1992 order. The request, which was dated January 19, 1993, was not mailed by certified or registered mail. Rather, the request was contained in an envelope which bore a postage date stamp of "January 22, 1993 p.m."

On January 27, 1993, the Board mailed a computer generated letter to all 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 all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's December 22, 1992 order was January 21, 1993. Claimant's request, which was dated January 19, 1993, was not mailed by certified or registered mail. Since claimant's request was received by the Board on January 25, 1993, more than 30 days after the Referee's December 22, 1992 order, it is presumed to be untimely until claimant establishes that the mailing was timely. OAR 438-05-046(1)(b).

A further review of this record confirms that claimant will be unable to rebut the aforementioned presumption. Specifically, the postage date stamp on the envelope which contained claimant's request stated "January 22, 1993, p.m." Such information establishes that the request was mailed to the Board on the 31st day after the Referee's December 22, 1992 order. Thus, claimant will not be able to establish that he mailed his request for review within 30 days of the Referee's December 22, 1992 order.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Finally, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. Alfred F. Puglisi, 39 Van Natta 310 (1987).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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February 5, 1993 Cite as 45 Van Natta 157 (1993)

In the Matter of the Compensation of
**RANDEL G. JENSEN, Claimant**
WCB Case No. 92-02227
ORDER OF ABATEMENT
Hollander & Lebenbaum, Claimant Attorneys
Lane, et al., Defense Attorneys

Claimant has requested reconsideration of our January 26, 1992 Order on Review. Specifically claimant contends that we erred in finding that he was not entitled to interim compensation.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. The self-insured employer is requested to file a response within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**TIMOTHY H. KRUSHWITZ, Claimant**
WCB Case No. 91-09218
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Neal's order that: (1) found that claimant's back injury claim was not prematurely closed; (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable conduct in requesting claim closure; and (3) affirmed an Order on Reconsideration that awarded no permanent disability. On review, claimant argues that: (1) the temporary rule the Referee applied in determining claimant's medically stationary status is invalid; and (2) the Order on Reconsideration is invalid because a medical arbiter was not appointed. The issues on review are premature closure, penalties, attorney fees, extent of unscheduled permanent disability, and validity of the WCD's Order on Reconsideration. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following corrections and supplementation. The dates listed as "1991" in the first three paragraphs of the findings of fact should be listed as "1990."

On August 24, 1990, the insurer received a response from Dr. Hyland, treating chiropractor, regarding its August 17, 1990 inquiry about the status of claimant's condition. (Exs. 6A, 7). Dr. Hyland noted that claimant was not medically stationary and estimated that he required four more weeks of chiropractic care. (Ex. 7).

## CONCLUSIONS OF LAW AND OPINION

### Premature Closure

The Referee applied former OAR 436-30-035(7)(c) in determining that claimant's claim had not been prematurely closed because he had not sought medical treatment for more than 28 days before the October 12, 1990 Determination Order. (WCD Admin. Order 7-1990, effective July 1, 1990 (temp)). We find that a preponderance of the medical evidence establishes that claimant was not medically stationary when his claim was closed.

Claimant argues that the temporary rules adopted by WCD Admin. Order 7-1990 are invalid because they were adopted in violation of the required rulemaking procedures. We recently addressed the same question regarding temporary standards adopted by WCD Admin. Orders 15-1990 and 20-1990. Eileen N. Ferguson, 44 Van Natta 1811 (1992). In Ferguson, supra, we held that we have no authority to declare a rule, promulgated by the Director, invalid for failure to comply with rule making procedures.

We are bound by the rules promulgated by the Director insofar as they are consistent with the Workers' Compensation Act, and the authority granted the Director by the Act. See Miller v. Employment Division, 290 Or 285 (1980); Charles M. Anderson, 43 Van Natta 463 (1991). However, where there is a conflict between an administrative rule and a substantive provision of ORS Chapter 656, it is the statute rather than the rule which controls. In such circumstances, we apply the statute and give no effect to the rule. Forney v. Western States Plywood, 66 Or App 155 (1983); Walden J. Beebe, 43 Van Natta 2430 (1991). Here, we find that there is a conflict between the Workers' Compensation Division's (WCD) interpretation and application of former OAR 436-30-035(7)(c) in this case and the substantive provisions of ORS 656.005(17) and ORS 656.268(1).

The definition of "medically stationary" was not changed by the 1990 amendments. ORS 656.005(17) provides that "'[m]edically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." This is fundamentally a medical question, consistently treated as such by this Board and the appellate courts in the many times that we have applied this statutory definition. See, e.g., Harmon v. SAIF, 54 Or App 121, 125 (1981);

Austin v. SAIF, 48 Or App 7, 12 (1980) (the question of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence). In addition to this provision, ORS 656.268(1) provides that "claims shall not be closed if the worker's condition has not become medically stationary."

In contrast, former OAR 436-30-035(7)(c), as interpreted and applied by the WCD in this case, mandates a medically stationary date strictly based on the lapse of a certain period of time, even in the face of competent medical evidence that would establish some other date. Former OAR 436-30-035 provides, in pertinent part:

> "(1) A worker's condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.
>
> "* * * *
>
> "(7) Notwithstanding section (1) of this rule, where applicable, a worker shall be determined to be medically stationary on the earliest of the following dates:
>
> "* * * *
>
> "(c) If the worker has not sought medical care for a period in excess of 28 days, unless so instructed by the attending physician, on the date the worker last sought medical care."

Notwithstanding former OAR 436-30-035(7)(c), or more accurately, the WCD's interpretation and application of it in this case, we conclude that the mere passage of time without medical treatment cannot support a finding of medically stationary status when competent medical evidence establishes that the worker's condition was not medically stationary as that term is defined by statute. The fact that the worker has not sought treatment for a period of time might, in some cases, go to the weight to be accorded a doctor's opinion that the worker's condition would improve with treatment. However, the passage of time alone does not control the medical evidence, but is instead, but one factor that the trier of the facts might consider in appropriate cases when weighing the medical evidence. By requiring a finding of medically stationary status notwithstanding the existence of competent medical evidence to the contrary, the WCD's rule interpretation and application conflicts with ORS 656.005(17) and ORS 656.268(1), and we therefore apply the governing statutes under which the medical evidence must be considered.

Here, at the time of claim closure, Dr. Hyland provided the only medical evidence regarding claimant's medically stationary status. Dr. Hyland's report indicated that claimant was not medically stationary. (Ex. 7). Furthermore, in a July 22, 1991 chart note, Dr. Nicholson indicated that claimant had yet to become medically stationary, thus supporting Dr. Hyland's earlier finding that claimant was not medically stationary as of August 1990. (Ex. 9-2). Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987) (evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure).

Dr. Hyland was claimant's treating physician at the time he rendered his opinion regarding claimant's medically stationary status. 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). Here, there are no persuasive reasons not to defer to the opinion of Dr. Hyland. Thus, we find that claimant has established that he was not medically stationary when his claim was closed.

To the extent that the insurer argues that the report of Dr. Hyland should not be considered because, as a chiropractor, he was not qualified to act as claimant's attending physician at the time he submitted that report, we find that argument unpersuasive for two reasons. First, we find no statutory prohibition against relying on a chiropractor's opinion regarding medically stationary status. A chiropractor is restricted by statute in his or her ability to act as an attending physician and thereby has

limited ability to authorize temporary disability benefits and no authority to make findings of impairment for all practical purposes. ORS 656.005(12)(b)(B); 656.245(3)(b)(B). However, there is no such restriction in the statutes effecting a chiropractor's competence to render an opinion regarding the medically stationary status of a worker he or she is treating.

Second, the insurer cannot rely on the fact that claimant did not comply with the 1990 amendments and seek a physician qualified to serve as an attending physician to render an opinion regarding his medically stationary status when the insurer itself failed to comply with the Director's notification process regarding how changes occurring after July 1, 1990 would affect claimant. Sandra L. Masters, 44 Van Natta 1870 (1992). Department of Insurance and Finance Bulletin No. 215 (June 8, 1990) required that insurers provide written notice of the affect of the 1990 amendments to workers with accepted or deferred claims who were receiving medical services from physicians who, on July 1, 1990, would become nonattending physicians. In Sandra L. Masters, we held that a self-insured employer could not unilaterally terminate temporary disability benefits in reliance on the fact that the treating chiropractor who authorized the benefits was no longer authorized to act as an attending physician where the employer failed to follow the Director's "notification procedure" provided in Bulletin 215.

Here, the Masters reasoning is even more compelling. Not only did the insurer fail to give claimant notice as provided by Bulletin 215, the insurer essentially referred claimant to Dr. Hyland for an opinion concerning claimant's medically stationary status. (Ex. 6A). Claimant relied on that referral by going to Dr. Hyland, who responded by providing his opinion on the subject. (Exs. 6-1, 7). Clearly, the insurer is estopped to argue now that the Board should disregard or discount Dr. Hyland's opinion because he was no longer qualified to act as claimant's attending physician. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992).

In any event, as previously discussed, nothing in the 1990 statutory amendments renders chiropractors incompetent to offer an opinion concerning an injured worker's medically stationary status, and there is no statutory basis which precludes the Board from relying on such an opinion.

Accordingly, based on this record, we find that claimant was not medically stationary when his claim was closed.

Penalties and Attorney Fees

The Referee assessed no penalties and attorney fees because she did not find the insurer's conduct unreasonable in requesting claim closure. Claimant argues that the insurer's closure in reliance on former OAR 436-30-035(7)(c) was unreasonable because he was not actually medically stationary at the time his claim was closed.

We have found former OAR 436-30-035(7)(c) to be without effect to the extent that it mandates a medically stationary date based solely on the passage of time without medical treatment and does not consider competent medical evidence regarding a worker's medically stationary status. We have also found that, based on competent medical evidence, claimant was not medically stationary at claim closure. However, we find that the insurer did not act unreasonably in relying on a validly enacted rule. See Darcine L. Fox, 44 Van Natta 1 (1992); Mary E. Weaver, 43 Van Natta 2618, 2619 (1991) ("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.").

Extent of Unscheduled Permanent Disability and Validity of the Order on Reconsideration

Because we find that claimant's claim was prematurely closed, we do not reach the issues of extent of unscheduled permanent disability and the validity of the Order on Reconsideration.

Attorney Fees For Prevailing on the Issue of Premature Closure

We have found that claimant's claim was prematurely closed. Inasmuch as our finding will result in increased temporary disability benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-15-055; Dianne M.

Bacon, 43 Van Natta 1930 (1991). Consequently, claimant's counsel is entitled to 25 percent of the increased temporary disability benefits created by our order, not to exceed $3,800.

ORDER

The Referee's order dated October 22, 1991 is reversed in part and affirmed in part. The October 12, 1990 Determination Order is set aside as premature. The claim is remanded to the insurer for further processing. Claimant's counsel is awarded 25 percent of the increased compensation created by the Board's order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

**Board Chair Neidig, concurring:**

I agree with the majority that in this instance, where the insurer had medical evidence indicating that claimant was not medically stationary, the application of former OAR 436-30-035(7) to close claimant's claim was inappropriate. However, I believe it should be emphasized that the majority opinion does not hold that the use of that administrative provision is inappropriate in all situations. Rather the administrative rule may be used in those situations where its application does not conflict with statutory provisions.

**Board Member Kinsley concurring:**

I concur with the result reached by the majority opinion, but I base my concurrence on the following reasoning.

I do not read former OAR 436-30-035(7)(c) (Administrative Order 7-1990) to be a rule that was promulgated so as to be in direct conflict with ORS 656.005(17) and ORS 656.268(1). In my view, this rule can be properly used to enable the insurer or employer to get on with the business with processing a claim to closure when it appears that the claimant is no longer actively following medical advice so that his or her condition may be found to have reached a medically stationary status.

I liken these rules to the Board's rule at OAR 438-06-071(1) which allows a referee to dismiss a request for hearing if the person requesting the hearing "has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days."

These rules recognize that the person who is attempting to obtain some benefit or relief from the workers' compensation system has an obligation to stay active on the claim. Some claimants do, in fact, stop seeking medical care, move away with no forwarding address or, for various reasons, lose contact with their doctors, the employer and the insurer. If the insurer had to wait for another medical report to close the claim, that day would never come. The Department had a valid administrative reason as a basis for the adoption of the rule. This rule is necessary for the orderly processing of claims in those appropriate cases where a claimant has made himself or herself unavailable. Therefore, there is no reason that the Board must "give no effect to the rule." Order on Review, p. 2. Rather, it is more appropriate that we merely find the rule inapplicable to this case.

In the case at hand, the insurer wrote claimant on August 17, 1990 and informed him that claimant had not been seen by Dr. Hyland since July 3, 1990, that the claim could not be held in open status indefinitely, and that, if claimant was still having difficulty due to his injury, he should contact his employer and doctor. The insurer further indicated that if they or his doctor had not heard from claimant within two weeks (by August 31), they would assume that claimant had recovered from his injury without disability and proceed to close his claim. Exhibit 6a. In fact, the insurer had previously received chart notes on August 1, 1990 showing that claimant had received treatment subsequent to July 3 on July 13, July 17 and July 27. Exhibit 2-3. The record further shows that claimant received treatment on August 8, August 15, August 22, August 24 and September 5. Exhibit 6-1. There is no indication when the insurer received Exhibit 6-1. However, these chart notes show that claimant had not abandoned his claim by failing to seek medical care. A telephone call to the chiropractor's office by the insurer would have verified that fact.

Also on August 17, 1990, the insurer wrote to Dr. Hyland for a status update on claimant's condition. In his August 21, 1990 report he stated that he had last treated claimant on August 15. (This response did verify at least one of the treatment dates indicated in Exhibit 6-1.) He further stated that claimant's condition was not medically stationary and that he anticipated claimant becoming medically stationary in "4 wks (approx)." Exhibit 7. Four weeks later would have been September 18. He further stated, "Pt. still requires curative chiropractic care for this injury."

On September 10, 1990, the insurer requested a determination order closing the claim and giving the explanation for the request as "NO RESPONSE TO RECOVERY LETTER." Exhibit 7A. In fact, the insurer had received the response from Dr. Hyland on August 24. Exhibit 7.

The Department issued a Determination Order on October 12, 1990 which found claimant's condition to be stationary on August 31, 1990. The Department issued an Order on Reconsideration on July 11, 1991 which found claimant's condition stationary on September 10, 1991.[1]

At the reconsideration, the Department disregarded Dr. Hyland's August 21, 1990 response because, at that point in time, he was not a qualified attending physician for claimant. Dr. Hyland is a chiropractor and it was past thirty days and twelve visits from the date of injury. See ORS 656.245(3)(b)(A). However, as the majority opinion points out, although Dr. Hyland was prohibited from providing authorized treatment, there was no prohibition from Dr. Hyland rendering an opinion as to claimant's medically stationary status. Dr. Hyland had been regularly treating claimant, so he would be in a good position to judge claimant's progress. There is no apparent reason, therefore, not to rely on Dr. Hyland's opinion.

It is also apparent from the record that claimant had not abandoned his claim. Again, as the majority opinion points out, there is no evidence that claimant was made aware of the change in the law that he must seek care from someone other than a chiropractor. He continued to seek treatment from Dr. Hyland for relief from the symptoms caused by his compensable injury.

Based on the above, I believe it was inappropriate to apply former OAR 436-30-035(7) and (8) from WCB Administrative Order 33-1990 to close claimant's claim because those rules were inapplicable. It was also inappropriate to close the claim based on the applicable rule, former OAR 436-30-035(7)(c), since claimant had clearly not abandoned his claim and he was following up on medical care that, to his knowledge, was appropriate.

In considering the merits of this claim to determine when and if claimant's condition became stationary, the record shows that, at the time the claim was closed, Dr. Hyland had only "anticipated" that claimant would be medically stationary about September 18, 1990. There is no follow up shown in the record to confirm that forecast. Therefore, I conclude with the majority that the July 11, 1991 Order on Reconsideration and October 12, 1990 Determination Order should be set aside and this claim should be remanded to the insurer for further processing.

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[1] They arrived at that latter date by applying OAR 436-30-035(8) (WCB Administrative Order 33-1990). This rule was not applicable. See OAR 438-10-010 (WCB Administrative Order 5-1992). However, that rule states that a claimant is presumed to be medically stationary ten days from the expected date of response to an insurer's notification letter pursuant to section (7) of that rule, unless subsequent medical evidence based on actual examination is persuasive that the claimant was not stationary on that date.

In the Matter of the Compensation of
**JEANNE C. RUSCH, Claimant**
WCB Case No. 91-06552
ORDER ON REVIEW
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig, Hooton and Moller.

The self-insured employer requests review of that portion of Referee Howell's order which: (1) found that claimant had established "good cause" for her untimely hearing request from the employer's denial of claimant's low back condition; (2) set aside the employer's denial insofar as it denied claimant's current low back condition; and (3) set aside the employer's denial insofar as it denied palliative medical services. The employer moves to strike claimant's respondent brief as based on evidence not contained in the record. On review, the issues are motion to strike, timeliness, jurisdiction, compensability, and medical services. We reverse in part and vacate in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the second page of his "Ultimate Findings of Fact."

## CONCLUSIONS OF LAW AND OPINION

Before proceeding with our review, we address the employer's argument that claimant has argued evidence not addressed at hearing. To the extent that claimant refers to matters that are not in the record, those matters have not been considered on review. Edgar L. Kinnett, 43 Van Natta 1240, 1241 (1991).

Finding that claimant's untimely hearing request was due to her reliance on her attorney's express representation that an appeal had been filed, the Referee concluded that claimant had established good cause to excuse her failure to request a hearing within 60 days. We disagree.

A request for hearing must be filed not later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

The test for determining whether "good cause" exists has been equated with the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71(B)(1) and former ORS 18.1160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (9186). Neglect by an attorney does not constitute good cause. See Sekermestrovich v. SAIF, 280 Or 723, 727 (1977); EBI Companies v. Lorence, 72 Or App 75, 78 (1985). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Here, claimant did not request a hearing on the February 27, 1991 denial until May 28, 1991, more than 60 days, but less than 180 days after the employer's denial. Claimant testified that she received the employer's February 27, 1991 denial on February 28, 1991. She read the entire letter and understood that to obtain a hearing she had to file a request within 60 days. Soon after receiving the denial, and within 60 days, claimant took the letter to her attorney. Claimant later delivered a blank hearing request form to her attorney. On more than one subsequent occasion her attorney informed claimant that he had filed the request for hearing.

After receiving no notice of a hearing date, claimant contacted the Workers' Compensation Division and was informed that a request for hearing had not been filed. Thereafter, claimant obtained another blank hearing request form and, on May 28, 1991, she filed a request for hearing herself.

Because failure to request a hearing due to negligence by an attorney is not excusable neglect, we hold that claimant has failed to establish good cause for her untimely request and her request for a hearing as to the employer's denial should have been dismissed for lack of jurisdiction. See Sekermestrovich v. SAIF, supra; EBI Companies v. Lorence, supra. Furthermore, we find that claimant's prior dissatisfaction with her attorney's work on her claim prewarned her to a probability of further dilatory problems. Moreover, claimant demonstrated that she knew how to obtain a hearing request form. Finally, the record establishes that she knew how to determine whether her hearing request had been filed.

Under the circumstances, we find that claimant's failure to ensure that her hearing request was filed before the expiration of the 60 days was also negligence on her part. Inasmuch as we conclude that claimant failed to establish good cause for her untimely request for hearing, claimant's hearing request concerning the employer's denial shall be dismissed. Thus, those portions of the Referee's order which set aside the employer's denial of claimant's current low back condition and palliative medical treatment are reversed.

Subsequent to the Referee's order, we have reasoned that a dispute concerning whether treatments are palliative or curative generally concerns the effectiveness and appropriateness of the medical treatment at issue. See Gladys M. Theodore, 44 Van Natta 905 (1992). Accordingly, because a proceeding for resolving such a dispute is otherwise provided in ORS 656.327, we have held that original jurisdiction lies exclusively with the Director. Id. Thus, had the medical treatment issue been properly before the Referee, we would have vacated the Referee's order insofar as it purported to set aside the employer's denial of claimant's palliative medical services.

ORDER

The Referee's order dated February 3, 1992 is reversed. Claimant's request for hearing is dismissed. The employer's denial is reinstated.

**Board Member Moller, dissenting.**

Because I believe that the Referee correctly found that claimant has established "good cause" to justify her failure to timely file her request for hearing, I respectfully dissent.

Citing Sekermestrovich v. SAIF, 280 Or 723 (1977) and EBI Companies v. Lorence, 72 Or App 75 (1985), the majority concludes that the negligence of claimant's attorney does not excuse claimant's untimely filing of her request for hearing. Moreover, the majority further concludes that claimant herself was negligent by failing to ensure timely filing of her request for hearing. I cannot conclude, on the facts here, that claimant's conduct was negligent. Nor do I find the holdings in Sekermestrovich and Lorence to be controlling.

Had this case solely involved a question of "ordinary negligence" on the part of claimant's attorney, I would agree that the failure of claimant's attorney to timely file a request for hearing does not constitute good cause for late filing. However, as the Referee found, an additional reason existed for claimant's untimely filing -- the false representations of claimant's attorney. In this regard, on more than one occasion prior to expiration of the filing period, claimant asked her attorney whether a request had been filed and was told that one had been filed. Thus, this case involves more than a question of "ordinary negligence" as was involved in Sekermestrovich, supra at 726. For that reason I would conclude that Sekermestrovich and its progeny are not controlling here. Moreover, because the record supports a finding that claimant would have timely filed her request but for the false representations of her attorney, I believe that her failure to timely file amounts to excusable neglect.

The majority further premises its conclusion on the fact that claimant's counsel had been dilatory in the past so that she was "prewarned" of the probability of further dilatory problems. However, claimant's conduct here was reasonably prudent considering her prior experiences with her attorney. After giving her attorney the employer's denial, claimant provided her attorney with a blank request-for-hearing form. Although prior dealings with her attorney alerted her to the possibility that he might be dilatory, she took steps to protect herself by her subsequent inquiries as to whether he had, in fact, filed the request. Moreover, on learning that her attorney had not timely filed a request for hearing, claimant herself filed such a request within 30 days of the expiration of the filing period, i.e., well within the 180-day "good cause" period established by ORS 656.319(1).

Under the circumstances presented here, I would conclude that claimant established "good cause" for the untimely filing of her request for hearing. Accordingly, I would affirm the Referee on this issue and address the merits of the claim. For these reasons, I dissent.

In the Matter of the Compensation of
**JUDY A. TUTTLE, Claimant**
WCB Case No. 91-05884
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Westerband, Kinsley, and Gunn.

The SAIF Corporation requests review of Referee Michael V. Johnson's order that: (1) found that a Disputed Claim Settlement (DCS) between SAIF and claimant did not preclude claimant from claiming medical services for a current bilateral upper extremity fibromyalgia condition; and (2) set aside SAIF's denial of claimant's claim for medical services. On review, the issues are whether the claim is precluded and if not, compensability of medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim for medical services for a current fibromyalgia condition is not precluded by the parties' March 14, 1991 DCS and that the claim is compensable under the terms of that agreement. We reverse.

The settlement agreement records the employer's and SAIF's contentions that:

> "[T]he injuries sustained on April 26, 1988, have resolved and that neither the compensable injury, activities while working for [the employer] or the accepted condition is the major and/or material contributing cause of the claimant's current conditions/disability, underlying disease process, resultant conditions, or need for treatment." (Ex. 7-4-5)

The agreement further provides in relevant part:

> "SAIF Corporation Denial
> * * * [We] issue this current condition denial of your cervical and bilateral shoulder condition, inflammatory and rheumatoid arthritis, possible early RSD, hormone deficiency, Reynauds disease,and psychological component for the resultant conditions of these ancillary conditions as being unrelated to the accepted condition.
>
> " SAIF will continue to provide medical benefits related to your accepted condition and herein further identifies that as related to the bilateral wrist carpal tunnel condition which has undergone a surgical procedure and has since resolved." (Ex. 7-2-3).

In addition, the parties agreed:

> "Denial Remains in Full Force and Effect
> Claimant understands that if the referee approves this agreement, SAIF Corporation's denials, as supplemented by the contentions of the employer and SAIF Corporation stated in this agreement, shall remain in full force and effect. Claimant shall have no further right to compensation or any other legal right related to the denied treatment or conditions. However, claimant retains rights under ORS 656.245, 656.273, 656.278, or 656.340 insofar as these rights may be related to the accepted bilateral wrist carpal tunnel condition and claimant is able to prove, by a preponderance of medical evidence, that the accepted compensable injury is a major contributing cause of her disability and need for medical care." (Ex. 7-5-6).

Under the terms of the agreement, claimant accepted SAIF's and the employer's contentions that the compensable condition of bilateral carpal tunnel syndrome had resolved and that claimant's other conditions when the DCS issued for which claimant was seeking treatment were not related to the compensable injury, the accepted condition or claimant's work for the employer. Thus, by virtue of the DCS, the parties agreed that claimant's then-current condition, however diagnosed, was not compensable. See Gilkey v. SAIF, 113 Or App 314 (1992); Southwest Forest Industries v. Archer, 109

Or App 349 (1991); Proctor v. SAIF, 68 Or App 333, 336 (1984). Claimant may avoid the preclusive effect of the DCS only if she establishes that her current need for treatment is for a condition different from the condition at the time of the DCS. See Southwest Forest Industries v. Archer, supra; Esther M. Wasson, 44 Van Natta 858 (1992).

In January 1991, Dr. MacKinnon, former treating rheumatologist, recorded claimant's bilateral hand symptoms, including impaired sensation and suspected loss of grip strength, as well as myofascial neck and shoulder pain. (See Ex. 6A). MacKinnon diagnosed "myofascial pain with generalized fibromyalgia." (Ex. 6B). Thereafter, claimant moved and sought treatment for her continuing symptoms from Dr. Becker, rheumatologist. Becker first saw claimant on March 1, 1991.

The DCS issued on March 14, 1991. (Ex. 7-8).

On June 7, 1991, Becker opined that there is no evidence that claimant's "initial condition has resolved," noting that "[h]er symptoms are still very similar to what she had at the time when she was first injured." (Ex. 15-1; see Exs. 16, 18A; 21-9; 21-25-6). Becker's conclusion that claimant still has the "same condition she's had all along" is uncontroverted. (Ex. 21-32). On this evidence, claimant has not established that the condition for which she currently claims medical services is different from her condition at the time of the DCS. Therefore, the claim for medical services related to the unchanged condition is precluded by the settlement agreement. See Southwest Forest Industries, supra.

Finally, we note that, if the claim were not precluded, the DCS does provide that claimant retains rights under Chapter 656

> "insofar as these rights may be related to the accepted bilateral carpal tunnel condition and claimant is able to prove by a preponderance of medical evidence that the accepted compensable injury is a major contributing cause of her disability and need for medical care." (Ex. 7-6, emphasis added).

However, because the claim is precluded under the terms of the agreement, we do not determine whether the claimed medical services would be compensable under other circumstances. See Esther M. Wasson, supra.

ORDER

The Referee's order dated March 6, 1992 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,200 attorney fee award is reversed.

**Board member Gunn dissenting.**

As a matter of law, I must disagree with my respected colleagues.

To begin, the majority errs in its conclusion that claimant accepted SAIF's and the employer's contentions that: (1) her compensable condition of bilateral carpal tunnel syndrome had resolved; and (2) her other conditions, for which she was seeking treatment when the Disputed Claim Settlement issued, were not related to the compensable injury, the accepted condition or claimant's work for the employer. This is no more true than the converse: that SAIF and the employer, in like style, by virtue of entering into the DCS, accepted claimant's contentions that: (1) her "current condition" is work related; and (2) the work injury is the cause of her current problems.

The majority's interpretation transposes the bona fide dispute contentions into agreed upon terms. However, by the very nature of a disputed claim settlement, the parties do not abandon their opposing contentions. Rather, the parties merely agree to resolve the existing conflict, without a legal determination by a third party (e.g., Referee/judge).

For example, suppose a claimant asserts that her claim is compensable and the insurer disagrees and maintains that the claim is noncompensable. If the parties enter into a DCS, claimant has not now agreed that her claim is noncompensable (or visa versa). Rather, the parties have agreed to settle a dispute over compensability without agreeing as to whether the claim is compensable or not. Expressed differently, the parties agree that they cannot agree on compensability, therefore, they agree to settle the conflict themselves and agree to release their right to a determination by the appropriate legal authority. Other than agreeing that they cannot agree but that they will settle the difference between them, there

is no other agreement, except when or if the parties specifically and explicitly provide in the DCS that they have also agreed to go the extra step and make a determination themselves on the merits of the issue in dispute. Further, the parties in exact terms must provide what that ultimate outcome (actual agreement) is.

The majority, on the other hand, has utilized the dispute to prove the agreement. However, logic and law dictates that an agreement must be proven by means of the agreed upon (nondisputed) terms. Without the latter, there is no meeting of the minds, and thus, no intent to be bound by such terms.

Here, via the Disputed Claim Settlement, the parties disagreed upon: (1) whether claimant's carpal tunnel syndrome had resolved; and (2) whether the conditions for which she was seeking treatment for were compensable. However, the parties agreed upon the following two provisions: (1) claimant retained rights to her accepted bilateral carpal tunnel syndrome; and (2) did not retain rights to conditions denied. Thus, the only question remaining is what were the denied conditions which claimant released her rights to?

This question is answered under the section heading of: "SAIF Corporation Denial." The Disputed Claim Settlement provides that claimant is alleging (which SAIF is denying) that the following conditions are related to the April 1988 injury/disease:

(1) a cervical condition;
(2) a bilateral shoulder condition;
(3) inflammatory arthritis;
(4) rheumatoid arthritis;
(5) possibility of early RSD;
(6) a hormone deficiency
(7) Reynauds disease; and
(8) a psychological component.

Finally, the denial section of the agreement concludes that SAIF's position is that claimant's current disability, resultant condition, underlying disease or need for treatment is in dispute and therefore, SAIF is issuing "this current condition denial of [the conditions listed in (1) through (8)] as being unrelated to the accepted condition."

If this provision is interpreted as the majority proposes, the agreement would purport to provide that SAIF's current condition denial is a denial of the conditions listed in (1) through (8) in addition to unspecified conditions not in the agreement. This would be similar to allowing an insurer to dispose of a disputed claim for aggravation for a worsened accepted condition plus any other conditions, whether accepted or not, whether asserted or not, named or unnamed which might have worsened since the last arrangement of compensation. Or an insurer could dispose of a disputed claim for a new injury for a claimed injury plus other unclaimed, unnamed injuries.

Plain and simple, this can only be dubbed a "feathered fish" theory of compensation. In other words, it don't swim and it don't fly.

Furthermore, the majority relies upon Gilkey v. SAIF, 113 Or App 314 (1992); Southwest Forest Industries v. Archer, 109 Or App 349 (1991); and Proctor v. SAIF, 68 Or App 333, 336 (1984). However, these cases are distinguishable.

In Gilkey v. SAIF, supra, the claimant sustained a compensable hip injury. Subsequently, the claimant experienced increased hip pain and made a claim for a degenerative hip condition. The insurer denied the degenerative hip condition. The parties entered into a settlement agreement upon which they agreed that the claimant's denied degenerative hip condition was the result of noncompensable causes.

In Southwest Forest Industries v. Archer, supra, the claimant sustained a compensable dorsal lumbar back strain. Subsequently, the claimant returned to work but continued to experience back pain which was diagnosed as having a psychiatric or psychological origin. The claimant made a claim for an aggravation of his back condition. The insurer denied the back pain condition and the psychiatric origin of it. The parties entered into a DCS upon which they agreed that for a lump sum the claimant would release his rights to his contention that his "present problems and need for care is [sic] compensable."

In Proctor v. SAIF, supra, the claimant sustained a compensable physical injury. Subsequently, the claimant filed a claim for a psychological condition (i.e. psychogenic pain disorder). The insurer denied the psychological condition. The parties entered into a settlement agreement upon which they agreed that the claimant's psychological condition would remain in denied status as a noncompensable claim unrelated to the claimant's injury.

Each of these cases are distinguished for the same reason. They each deal with parties that have agreed to a specific condition to be released. In each of the cases discussed, the parties expressed the definite condition being denied for which claimant would agree to grant a release his or her rights.

Inasmuch as this is not the case here, those cases are not applicable to the present one.

More recently, in Wasson v. Evanite Fiber Corp., 117 Or App 246 (1992), the court found that the claimant could not claim that her depression had worsened, "because it was the same condition that had been denied in the DCS." (Emphasis supplied). A further distinction in all of these cases, is that the condition subsequently claimed had actually been denied in the Disputed Claim Settlement, not presumed denied.

Accordingly, the case before us, unlike the aforementioned cases, requires that we interpret the parties' agreement to determine if the agreement foreclosed claimant's right to compensation for a fibromyalgia condition. In interpreting any stipulation or DCS, we treat such a document as a contract between the parties and interpret it accordingly. Mary Lou Claypool, 34 Van Natta 943 (1982).

Contract law provides that if the objective manifestations of the parties appear to be perfectly clear but subsequent facts reveals a latent ambiguity which may be reasonably interpreted in either of two ways, then it is necessary to receive evidence of what each party subsequently thought at the time of the contracting. Such is the case here.

At hearing, claimant testified that she understood that after signing the DCS, she would still be entitled to medical treatment for her wrists and arms condition. (Tr. 16-22). She testified that she was not aware that her current treatment was for a fibromyalgia condition. (Tr. 20). She testified that when she signed the agreement, her intent was not to agree with SAIF's contention that her compensable carpal tunnel syndrome had resolved. (Tr. 20).

In rebuttal, Reg Gregory, the claims adjustor who negotiated the DCS agreement, testified at hearing. He indicated that his intention was that the fibromyalgia condition would be a denied condition by means of the DCS agreement. (Tr. 25).

Upon review of the record, I would find claimant's testimony to be the more persuasive. Further, I would find claimant's testimony to be illustrative of the intended purpose of the DCS on the basis that her testimony is consistent with the wording of the DCS.

At hearing, SAIF's counsel's asked claimant:

> "Now, when you entered into this Disputed Claim Settlement, did you understand that the only thing that we would pay for would be compression of the median nerve which is known as carpal tunnel syndrome in each hand?" (Tr. 16).

Claimant responded:

> "I understood that they would take care of the medical problems with my hands and wrists -- from my arms and wrists, excuse me, wrists and hands -- whatever." (Tr. 17).

I note that SAIF's contention (i.e., the DCS provided only for the payment of the compression of the median nerve) is not supported by the document itself. As discussed, the DCS does not delineate that it will only pay for the carpal tunnel syndrome condition. Rather, it provides that it will continue to pay for the compensable condition and not pay for the conditions which claimant is making a claim for. Inasmuch as claimant testified that her physician had not made her aware that she was receiving treatment for fibromyalgia, her testimony supports a finding that only the specified conditions were intended to be disposed of by means of the DCS.

Additionally, SAIF's counsel's asked claimant:

> ". . . And when you signed this Disputed Claim Settlement agreement, did you recognize that you were agreeing at that point that your carpal tunnel syndrome at that moment had resolved?" (Tr. 20).

Claimant responded: "No." (Tr. 20).

Again, claimant's testimony is persuasive because, in fact, the DCS does not depict that the parties agreed that claimant's carpal tunnel syndrome had resolved. Rather, this was one of two of SAIF's assertions and one of the disputed contentions.

Therefore, considering that: (1) a fibromyalgia condition was not specifically mentioned; (2) claimant understood that her arms and wrists condition would be medically provided for; and (3) upon that reliance, and after the DCS issued, claimant proceeded to seek and receive medical treatment for her arms and wrists condition and submitted the medical claims to SAIF, all support a finding that the actual intention of the parties, at the time of the DCS, did not include a denial of the a fibromyalgia condition and a subsequent release of rights in regard to that condition.

The majority, however, reads the agreement to hold that the language: ". . . SAIF Corporation's denials, as supplemented by the contentions of the employer and SAIF Corporation stated in this agreement . . . " purports to deny any condition present at the time of the agreement, regardless of what, how or when diagnosed. The interpretation which the majority adopts ignores the legal maxim of: expressio unius, exclusio alterius (i.e., the expression of one thing is the exclusion of another.) Therefore, when interpreting documents and when certain persons or things are specified in a law, contract, or will, an intention to exclude all others from its operation may be inferred. The majority, however, allows the specific conditions listed in the agreement to be welded to the more general statement, providing the insurer with an unconditional waiver of any and all conditions existing at the time of the agreement.

In sum, if the majority is correct, then why bother to list any specific conditions? The majority's treatment of the DCS renders meaningless the denial of the specific conditions enunciated first and repeatedly referenced in the agreement. The majority adds language and meaning to the plain words of the agreement. Furthermore, contrary to policy to hold specific language over the general language in matters concerning a contract, the majority's conclusion substantially expands the value of the agreement. Therefore, and in particular, since the majority cites and relies upon cases which, unlike the instant case, all involve instances where a specific condition was listed in the agreement, I can find no basis in law to support the majority's conclusion.

Finally, I note that in Greenwade v. SAIF, 41 Or App 697 (1979), the court held that the disability suffered by the worker and the amount which he received in settlement of his claim did not provide a basis for setting aside the settlement entered into, because the dispute was as to whether the injury was compensable.

Under the Greenwade analysis, I observe that the central issue here, is not whether the fibromyalgia condition was compensable, but whether claimant released his rights to this disability when he released other conditions and thus, agreed that those conditions were to remain in denied status. Moreover, in the present case, claimant is not claiming that he is entitled to more compensation under the agreement. Rather, there is a disparity between what claimant agreed was denied (agreed to release) at the time of the DCS and what SAIF agreed was denied at the time of the DCS. Therefore, inasmuch the disparity here involves the extent of agreement's release, and I find that the agreement materially overlooks claimant's loss, I would hold that claimant's entitlement to appropriate medical services for her fibromyalgia condition has not been released, or at the very least, that the DCS can be successfully challenged on such a basis.

I find support for this conclusion from the Supreme Court case cited in Greenwade v. SAIF, supra:

> "It is clear from the purport of the entire act of 1965 that it was enacted in that spirited, or public policy, inherent in workmen's compensation statutes which will not bind the workman to an agreement regarding compensation which materially overlooks his loss and expenses resulting from the injury, or his disability, regardless of how well advised or observant he may have been at the time he entered into it. The fundamental thought behind this public policy is that workmen's compensation plans are made not only for the humane purposes of providing medical care and income for injured and

disabled workmen and to aid in maintenance of at stable group of workmen, but to benefit the public by having a fund administered in such a way that workmen will not be unemployed on account of injury or disability without treatment and basic income. An important facet of this is that if workmen were not thus aided they and their families often would become public charges." Schulz v. Compensation Department, 252 Or 211, 216-217 (1968).

For all of the above reasons, I respectfully dissent.

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February 5, 1993 Cite as 45 Van Natta 170 (1993)

In the Matter of the Compensation of
**MICHAEL W. YOKUM, Claimant**
WCB Case Nos. 91-14304, 91-14305, 91-14306, 91-14307, 91-14308, 91-14309 & 91-17992
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Jerome Larkin (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Garrett, et al., Defense Attorneys
Davis & Bostwick, Defense Attorneys
Beers, et al., Defense Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation, on behalf of Turner Painting (Turner/SAIF), requests review of Referee Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for chronic toxic encephalopathy (CTE) and chronic toxic labrynthitis (CTL); (2) upheld denials of SAIF, on behalf of E&C Painting; American States Insurance, on behalf of Productive Painting; SAIF, on behalf of Mid-Coast Marine; EBI Companies, on behalf of Reedsport Marine and Fabrication; SAIF, on behalf of Pacific Marine Ship Repair; and SAIF, on behalf of Asphalt Maintenance Association, Inc. (AMA/SAIF), for the same condition; and (3) awarded an assessed attorney fee of $19,187.50. In its Reply Brief, SAIF/Turner argues that the $11,768.75 attorney fee requested for services on review is excessive. On review, the issues are compensability and, if the claim is compensable, responsibility and attorney fees. We affirm in part, reverse in part and modify in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

## FINDINGS OF ULTIMATE FACT

Claimant's employment exposure to toxic substances was the major contributing cause of his CTE/CTL conditions.

Employment conditions at AMA/SAIF actually contributed to a worsening of claimant's compensable CTE/CTL condition.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

We adopt the Referee's "Opinion and Conclusion" on this issue, with the following supplementation.

Turner/SAIF is joined by several other employer/insurers (hereafter, the defense) in arguing that claimant has not proven that his work exposure was the major cause of his organic brain disorder. In this regard, the defense contends that the opinion of Dr. Morton, upon which claimant relies, is unpersuasive as it is based on an inaccurate understanding of claimant's drinking history. We disagree.

Morton reviewed, considered and relied on Dr. Colby's findings and opinion, (Ex. 21), which also considered claimant's drinking history. (See Tr. 158, 196-98, 218-19, 228). The defense offers no independent evidence contrary to our findings that claimant usually drank one to four beers at a time, about a six-pack a week, and about a half-case per week during his heaviest consumption. Rather, the defense contends that claimant misrepresented his drinking habits to Morton, thus rendering Morton's conclusions unreliable.

Morton acknowledged that his history was contradicted by Colby's, to the extent that claimant told Colby about drinking during the year prior to Morton's first examination, whereas claimant had told Morton that he had quit during that time. (Tr. 221). However, Morton found the variations between his history and Colby's to be clinically insignificant. (Tr. 229-231). Morton explained that he did not suspect drinking as a significant causal factor, because it had not been sufficiently excessive in claimant's case. Morton further doubted that claimant's CTE/CTL was due to alcohol abuse because claimant did not fit the behavior profile of such a patient. Thus, Morton was able to relate claimant's organic brain disorder to solvent exposure instead of drinking. (See Tr. 180-81; see also Tr. 232-33). In our view, Morton's opinion is well-reasoned and based on an accurate history.

Turner/SAIF urges us to discount Morton's conclusions, as we did in Michael J. Eby, 42 Van Natta 1345 (1990), aff'd mem 107 Or App 382 (1991). In Eby, Morton's opinion was found "highly questionable" regarding the cause of CTE, where the worker had a long history of heavy alcohol use. Michael J. Eby, supra at 1346-47. Moreover, in that case, Morton's history regarding the worker's substance abuse, solvent exposure and onset of symptoms was materially inaccurate and Morton relied on neuropsychological testing which was similarly unreliable. There was evidence that claimant's neurological deficits were attributable to marijuana abuse as well as alcohol. Id.

The present case is distinguishable from Eby, because the defense has not established that Morton's opinion is based on materially inaccurate facts. Moreover, although many examining physicians, including Morton, have identified alcohol abuse as a possible cause of CTE/CTL disorders, (see Exs. 44A-12; 38-5; 42-8), here no cause other than work exposure has been identified. (See Tr. 151). Consequently, we conclude, as did the Referee, that claimant has established that his work exposure to toxic organic chemicals was the major contributing cause of his current CTE/CTL conditions.

Responsibility

We adopt the first paragraph of the Referee's opinion on this issue and agree that responsibility is initially assigned to Turner/SAIF, based on the treatment sought from Dr. Mirka in November 1990, during claimant's employment with Turner. See Fred A. Nutter, 44 Van Natta 854 (1992). In Nutter, we held that where there is no accepted claim, responsibility for the compensable condition is assigned with the last employer/insurer prior to the onset of disability and, absent disability, we treat the date claimant first seeks medical treatment as the date of disability.

Turner/SAIF argues that it is not responsible for claimant's CTE/CTL conditions, because claimant first sought treatment for these conditions in 1987 (prior to his job with Turner) or, alternatively, that the subsequent exposure with AMA/SAIF contributed to the causation of the condition.

Concerning the first argument, we adopt the portion of the Referee's opinion which finds insufficient evidence to conclude that claimant sought treatment for his CTE/CTL in 1987 or any time prior to November 1990, during the Turner employment. However, we reach a different result regarding responsibility for the claim, based on the following reasoning.

To shift responsibility to AMA/SAIF (the subsequent employer), Turner/SAIF must prove that "the later employment conditions actually contributed to a worsening of the condition." Oregon Boilerworks v. Lott, 115 Or App 70, 74 (1992) (citations omitted). AMA was claimant's only employer after Turner and the only employer in 1991. AMA contends that claimant's "AMA" work exposure did not contribute to his condition. AMA relies on Morton's asserted lack of basis for suspecting that it did. In this regard, Morton testified that because he was not aware that claimant experienced any symptoms of intoxication while working for AMA, Morton had no basis for suspecting that that exposure contributed to his condition. (Tr. 226). However, we note that claimant sought treatment following exposure to toxic substances at AMA (see Ex. 43), and experienced symptoms of intoxication associated

with that exposure. (See Tr. 619-620, 629). In addition, claimant's 1991 work exposure and symptoms were documented contemporaneously by Dr. Colby as well as Dr. Morton. (Ex. 21-3). Based on Morton's reasoning regarding causation, which we have found to be persuasive, we conclude that claimant's exposure-related symptoms correlate with pathological damage, i.e., a worsening of his condition. (See Tr. 156-165). In other words, when claimant was exposed to toxic substances and experienced symptoms of intoxication associated with that exposure, his underlying CTE/CTL condition worsened. Based on this explanation, Morton's December 1991 chartnotes, which reported claimant's recent work with oil-based enamel, xylene and TSP as well as claimant's increased clumsiness during the latter half of 1991, (see Ex. 43-2), and Colby's similar contemporaneous reporting, we find that claimant's work for AMA did contribute to a worsening of his CTE/CTL condition. Consequently, responsibility for the compensable CTE/CTL condition shifts from Turner/SAIF to AMA/SAIF.

To shift responsibility for claimant's occupational disease to a prior employer/insurer, AMA/SAIF must show that a prior exposure was the sole cause of claimant's CTE/CTL or that it was impossible for claimant's exposure during his AMA/SAIF job to have caused his disability. FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984, clarified, 73 Or App 223 1985). Because claimant's "AMA" work did actually contribute to his condition, we conclude that AMA/SAIF has established neither fact. Accordingly, responsibility for claimant's CTE/CTL condition does not shift from AMA/SAIF to a prior employer/insurer.

Attorney fees

SAIF argues that the Referee's $19,187.50 attorney fee (for services at hearing) and claimant's requested $11,768.75 attorney fee (for services on review) are excessive. In support, SAIF cites Audrey J. Cameron, 43 Van Natta 1220 (1991), aff'd Higgins v. Schramm Plastics, 112 Or App 563 (1992). In that case, where compensability of a CTE condition was at issue, we awarded a lower attorney fee than claimant requested. Although that case was facially similar to the present case, the comparison is not instructive. Underlying the factors which we consider in determining reasonable attorney fees are numerous facts which vary considerably among cases. Therefore, the fee assessed in one case is not necessarily appropriate in another, even though there may be some similarities between the two cases.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's award of a $19,187.50 attorney fee for claimant's counsel's services at hearing concerning the compensability issue is reasonable. However, in light of our responsibility decision, AMA/SAIF, rather than Turner/SAIF, is responsible for the attorney fee. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented in part by the length of the hearing, the record, and claimant's counsel's statement of services), the complexity of the issue, the value to claimant of the interest involved, and the risk that claimant's counsel might go uncompensated.

Finally, concerning the attorney fee requested for services on review, we note that claimant's counsel is not entitled to an assessed fee for time expended regarding the attorney fee issue, because attorney fees do not constitute "compensation awarded to a claimant" under ORS 656.382(2). See Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Accordingly, after considering the factors set forth in OAR 438-15-010(4) and the time devoted to the other issues as represented by claimant's brief and claimant's counsel's well-documented statement of services, we find that a reasonable fee for claimant's attorney's services on review is $10,500. In reaching this conclusion, we have particularly considered the time devoted to the case, the value to claimant of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated February 13, 1992 is affirmed in part, reversed in part and modified in part. That portion of the order that set side the SAIF Corporation's denial, on behalf of Turner Painting, is reversed. SAIF/Turner's denial is reinstated and upheld. That portion of the order that upheld the denial of SAIF, on behalf of Asphalt Maintenance Association, Inc., is reversed. AMA/SAIF's denial is set aside and the claim is remanded to it for processing according to law. The Referee's order is modified so that the attorney fee assessed by the Referee is payable by AMA/SAIF. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $10,500, payable by AMA/SAIF.

In the Matter of the Compensation of
**DUANE C. GAULT, Claimant**
WCB Case No. 91-01278
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On January 22, 1993, we withdrew our December 31, 1992 order which reversed a Referee's order that directed the self-insured employer to pay claimant's scheduled permanent partial disability award at a rate of $305 per degree. We took this action to await the submission of the parties' proposed stipulation.

The parties have now submitted a proposed "Stipulation and Order," which is designed to resolve the rate of scheduled permanent disability issue. Specifically, the parties agree that claimant's scheduled permanent disability award shall be paid at a rate of $145 per degree unless and until the Supreme Court determines that awards such as claimant's shall be paid at a rate of $305 per degree.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**KEVIN NORTHCUT, Claimant**
WCB Case No. 91-16300
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members en banc.

The SAIF Corporation requests review of Referee Daughtry's order which awarded claimant a penalty pursuant to ORS 656.268(4)(g). On review, the issue is claimant's entitlement to a penalty. We affirm.

## FINDINGS OF FACT

Claimant's compensable right shoulder claim was closed by a February 26, 1990 Determination Order which awarded 20 percent unscheduled permanent disability. This award was based on an impairment value for reduced range of motion and weakness.

Claimant subsequently received further treatment for his shoulder and the claim was closed again by a February 28, 1991 Notice of Closure, which awarded no additional permanent disability.

Claimant requested reconsideration of SAIF's Notice of Closure by the Appellate Unit of the Workers' Compensation Division of the Department. A medical arbiter was appointed. Based on findings of impairment in the arbiter's report, claimant received an additional award of 10 percent unscheduled permanent disability.

Claimant requested a hearing, contending that he was entitled to a penalty because the Department's order both found that he was at least 20 percent disabled and increased his compensation by 25 percent or more beyond the amount awarded pursuant to SAIF's Notice of Closure.

## CONCLUSIONS OF LAW AND OPINION

Resolution of this case turns on the application of ORS 656.268(4)(g), which provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

Relying on the statute, the Referee awarded claimant a penalty in the amount of 25 percent of the increased compensation created by the Order on Reconsideration. In doing so, the Referee concluded that OAR 436-30-050(14), an administrative rule of the Department, was invalid and declined to apply it. That rule provides:

> "If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from new information obtained through a medical arbiter examination or from the promulgation of a temporary emergency rule, penalties will not be assessed." (Emphasis added).

As can be seen, the first sentence of the rule merely paraphrases the language of the statute. However, the second sentence of the rule adds a limitation not contained in the statute. If the rule is valid, then claimant here is not entitled to a penalty. However, as explained below, we agree with the Referee that the rule is invalid and we decline to apply it.

On review, SAIF argues that the Board is without authority to invalidate the Department's rule. SAIF argues that a rule promulgated under ORS 656.726(3), which provides the Director with such authority, is valid if it is within the range of discretion allowed by the more general policies of the Workers' Compensation Law. Black v. Department of Ins. and Finance, 108 Or App 437 (1991). Although SAIF acknowledges that the Department, through its rules, may not amend, alter, enlarge or limit the terms of a statute, see Cook v. Workers' Compensation Department, 306 Or 134 (1988), it argues that the Department may, by rule, fill in the "interstices in the legislation to aid in the accomplishment of the statute's purposes." U. of O. Co-oper. v. Dept. of Rev., 273 Or 539, 551 (1975). In the present case, SAIF contends, the Department has merely supplied a rule which recognizes that there will be instances when, in rating a claimant's disability, an insurer will not be able to consider information that subsequently arises at the time of reconsideration. SAIF argues that it should not be penalized for failing to take such information into account in rating extent of disability.

Claimant, however, argues that the statute is clear and provides no exception for the award of a penalty where a claimant is found to be at least 20 percent permanently disabled and his disability is increased by 25 percent or more, at the time of reconsideration. Claimant argues that it was the intent of the legislature to penalize carriers under such circumstances, and the Department has impermissibly amended the statutory provision through its promulgation of OAR 436-35-050(14). In support of his contention regarding the intent of the legislature to automatically penalize carriers in such situations, claimant cites to testimony from the Special Interim Committee on Workers' Compensation:

> Representative Derfler: I guess the question I have is going back to the penalty. If this information was not available at the time the insurance company made their closing and this additional information was added, then the penalty would still apply to the insurance company that didn't have that information and the award was increased or is that...?
>
> Mr. Tibbets: I believe that's the way it will happen, yes.
>
> Representative Derfler: So that even though they didn't have the information it still would be...?
>
> Mr. Tibbets: It would behoove them to encourage everybody to get the information in.

Mr. Dwinell: That was discussed and also part of our compromise.

Senator Kitzhaber: I imagine it was.

(Special Interim Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B, LC Draft 369-20.).

We conclude that the Referee correctly gave no effect to the administrative rule because the statute clearly provides for a penalty in such situations. In construing a legislative enactment, our first task is to discern the legislature's intent. If the language of the statute is unambiguous, ordinarily we apply it according to its plain meaning, without resort to legislative history. Satterfield v. Satterfield, 292 Or 780 (1982). If, however, the legislative purpose is unclear from the language of the enactment, we may consider legislative history as an aid in determining legislative intent. State v. Leathers, 271 Or 236 (1975).

Here, we find that the applicable statute, ORS 656.268(4)(g), is clear and unambiguous. Therefore, we conclude that the Department was without authority to interpret or complete the stated legislative intent. Springfield Ed. Assn. v. School District, 290 or 217 (1980). In this regard, the statute draws a "bright line" for determining the circumstances under which the award of a penalty is appropriate. If the facts of an individual case do not support the award of a penalty under ORS 656.268(4)(g), e.g., claimant's permanent disability award is increased by only 20 percent rather than 25 percent, then no penalty may be assessed even if the carrier's Notice of Closure was unreasonable.[1]

Furthermore, we conclude that even if the statute were unclear or did not itself fully express the intent of the legislature, the legislative history cited by claimant supports the proposition that the penalty was intended to be an automatic one, with no provision for exceptions involving increases created by newly discovered information or the promulgation of temporary emergency rules.

In reaching our conclusion, we acknowledge the Director's authority to promulgate rules which are reasonably required in the performance of his duties. See ORS 656.726(3)(a); Rager v. EBI Companies, 107 Or App 22 (1991). However, unlike the statutory scheme which provides the Director with broad authority to promulgate rules pertaining to the administration of medical services, the very precise terms of ORS 656.268(4)(g) do not provide the Director with the discretion to interpret the statute or create special circumstances under which it may not be applied. See also Timothy W. Reintzell, 44 Van Natta 1534, on recon 44 Van Natta 2091 (1992). Further, we note that the legislature could easily have drafted the statute in such a way as to reflect the approach taken in the Director's administrative rule. The legislature could have made ORS 656.268(4)(g) expressly dependent on unreasonable conduct by the carrier in closing a claim as was done in the immediately preceding provision -- ORS 656.268(4)(f). Similarly, unlike ORS 656.262(10), the statute at issue in this case does not require a finding that the carrier's conduct was unreasonable. For that reason, we find support for our conclusion that ORS 656.268(4)(g) does not permit interpretation by the Director.

Accordingly, we conclude that the Director's rule, OAR 436-30-050(14), is inconsistent with ORS 656.268(4)(g), the statute providing for assessment of a penalty in cases such as claimant's. We, therefore, agree that the Referee properly applied the statute and gave the rule no effect.

Although claimant submitted a brief on review, there is no attorney fee available for claimant's counsel's services on review where the only issue is entitlement to a penalty. Saxton v. SAIF, 80 Or App 631 (1986).

## ORDER

The Referee's order dated February 28, 1992 is affirmed.

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[1] Under such circumstances, a penalty might be assessable under ORS 656.268(4)(f).] Similarly, if the facts of an individual case do support the award of a penalty under ORS 656.268(4)(g), then a penalty shall be assessed. To the extent that the Department's rule purports to limit or amend the statute, we agree with the Referee that the rule should be given no effect.

**Board Members Neidig and Kinsley dissenting.**

The majority has concluded that the Director's rule, OAR 436-30-050(14) is inconsistent with ORS 656.268(4)(g), and therefore, must be given no effect. Because we believe that the majority attempts to improperly restrict the Director's authority to reasonably interpret the statute, we respectfully dissent.

We would agree with the majority's conclusion that ORS 656.268(4)(g) does not, on its face, provide for exceptions to the award of a penalty when increased compensation is created by an order on reconsideration. Additionally, although we do not agree with the majority's theory that the legislature intended to automatically penalize all insurers or employers whenever the increased award is sufficient to trigger the statute, we do agree that the penalty was envisioned to deter "lowballing," or undercompensating a worker in a Notice of Closure. However, we would nevertheless find that ORS 656.268(4)(g) cannot be appropriately applied without the kind of interpretation provided by the Director through his promulgation of an administrative rule.

It is well-established that review of agency action begins by recognizing that the legislature gives to the agency, not to the court, authority to fill in the "interstices" of the statutes they are required to administer. See e.g., U. of O. Co-oper. v. Dept. of Rev., 273 Or 539 (1975). In the present case, however, the majority's first error is that it assumes that there is no gap in the statute (or the statutory scheme providing for a reconsideration process) which must be filled by an administrative rule. We would find, however, that the statute is not as complete as the majority holds, and the Director was well within his authority to promulgate a rule in order to carry out the statute and the legislative intent. See ORS 656.726(3) and ORS 656.268.

Here, the gap in ORS 656.268(4)(g) becomes evident when the statute must be applied to the facts of each individual case. The statute does not specifically address the situations clarified by the administrative rule, and therefore, strict application of the statute does not allow for contemplation of the conditions recognized within the rule (i.e., additional permanent disability arising from a new temporary rule or new evidence stemming from an arbiter's exam). Further, we would suggest that the Director's rule, unlike the statute, acknowledges that evidence regarding a claimant's condition or the need for a new temporary rule to provide for claimant's unique disability would fall within the category of information that is better known to a claimant and his or her attorney, rather than to an insurer issuing a notice of closure.

The majority concludes that the legislature would have inserted language regarding the "reasonableness" of the insurer's conduct if it intended to allow such conduct to be assessed before awarding a penalty. However, we find it to be equally plausible that the legislature provided only the general authority for assessing such a penalty and left the details of the application of the statute to the agency that is most capable of understanding the circumstances that might give rise to an increased permanent disability award. The majority approach is inconsistent, as it recognizes that the penalty is to be assessed to deter certain conduct by insurers, yet it finds that the penalty must be automatically applied in situations where there was no unreasonable conduct on the part of the insurer.

The majority's second error is to focus upon one statute and disregard the entire statutory scheme providing for reconsideration. It would be impossible for the legislature to anticipate the effects of the simultaneous application of the statutes involved. For example, one statute requires the Director to promulgate temporary rules when, on reconsideration, he finds that certain types of impairment have not been provided for in the "standards." ORS 656.726(3)(f)(C). Yet, understandably, there is no evidence that the legislature anticipated the interaction between that statute, which will result in increased permanent disability to a claimant due to a discrepancy in the Department's standards, and a statute which the majority agrees was enacted to encourage insurers to properly assess a claimant's disability at the time of closure.[1]

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[1] The majority's interpretation of ORS 656.268(4)(g) indicates that the provision is not to be read in conjunction with ORS 656.382(1) and ORS 656.262(10). The approach ignores the statutory workers' compensation scheme which, in all other situations, provides for penalties only upon a finding of unreasonable conduct. See Price v. SAIF, 73 Or App 123 (1985); Duran v. SAIF, 87 Or App 509 (1987). The majority's holding in this case departs from that accepted principle of Workers' Compensation Law.

The following hypothetical illustrates the absurd result which would be reached by the majority's approach. An insurer receives a closing examination from a claimant's attending physician, evaluates the claimant's condition and awards 16 percent unscheduled permanent disability, which is the maximum amount allowed under the "standards." Coincidentally, after the notice of closure issues, the Director promulgates a temporary rule providing for a new impairment award for a type of impairment that was not previously contemplated by the standards. As a result, upon reconsideration the Department finds that the claimant has the type of impairment that was not previously provided for in the standards. Consequently, claimant's total award is increased to 26 percent.

Under the majority's scenario, the insurer would be automatically penalized for its failure to divine action that had not yet been taken by the Director. Similarly, an insurer will also be penalized for not being capable of guessing what new information might be discovered at the time of the medical arbiter's exam. The majority opinion fails to explain how an insurer could reasonably be expected to know such information or to take such considerations into account when it issues a notice of closure.

Because it is not possible for the legislature to anticipate every statutory interaction or even the kind of situation described above, we believe that promulgation of reasonable administrative rules to carry out the legislative intent is best left to the Director. Rules such as OAR 436-30-050(14) ensure an even-handed application of the statute and recognize that subsequent promulgation of a new temporary rule or the discovery of new evidence during the medical arbiter's exam constitute circumstances beyond the control of an insurer. For that reason, we find that the Director's rule provides an equitable approach that both provides for the majority's desire to penalize an insurer or employer when its Notice of Closure award is too low, yet recognizes that the application of the statute must include considerations that the statute did not address.

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February 8, 1993 Cite as 45 Van Natta 177 (1993)

In the Matter of the Compensation of
**MORRIS W. SALTEKOFF, Claimant**
Own Motion No. 91-0141M
OWN MOTION ORDER OF ABATEMENT
Martin McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 7, 1993 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF Corporation is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CAROLE A. VANLANEN, Claimant**
WCB Case No. 91-13600
ORDER DENYING RECONSIDERATION
Galton, et al., Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our August 11, 1992 Order on Review that affirmed a Referee's order which: (1) found that SAIF could not stay claimant's temporary or permanent disability awards pending its appeal of an earlier referee's compensability decision; and (2) assessed a penalty and attorney fee for allegedly unreasonable claim processing. Carole A. Vanlanen, 44 Van Natta 1614 (1992). Contending that our holding is inconsistent with the Board's recent decision in Felipe A. Rocha, 45 Van Natta 47 (1993), SAIF asks that we withdraw our prior order for further consideration.

SAIF has petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

After review of SAIF's request, we decline to withdraw our August 11, 1992 order. We reach this decision based on the following reasoning.

Our prior order was primarily based on the rationale articulated in Carol D. Goss, 43 Van Natta 2637 (1991), which concluded that a carrier's appeal of a compensability decision did not stay its obligation to pay a subsequently issued Determination Order temporary and permanent disability award. The Board recently revisited the Goss reasoning in Felipe A. Rocha, supra, and held that a carrier was entitled to stay the payment of "pre-litigation order" temporary disability granted by a Notice of Closure pending the completion of its appeal of a compensability decision. To the extent that its holding was inconsistent with the Goss rationale, the Board stated that the Goss reasoning was disavowed.

Were this case currently pending review before us, different reasoning would likely be applied. Nonetheless, this matter is presently before the court, where the parties can present their respective arguments, which will undoubtedly include a reference to the Rocha decision. Considering the current posture of this case and the virtual certainty that this legal issue (the scope of the "stay of compensation" provisions of ORS 656.313) would ultimately be presented to the court whatever our decision would be, we decline the request to withdraw our prior order for reconsideration. We consider such an action to be in the interests of judicial and administrative efficiency by expediting the ultimate resolution of a legal issue which can have profound implications on the workers' compensation system.

Finally, claimant seeks an attorney fee for her counsel's services in responding to SAIF's request. She relies on ORS 656.382(2), which provides for an assessed attorney fee if a carrier initiates a request for Board review and the Board finds that claimant's compensation should not be disallowed or reduced. We decline to grant claimant's request.

We have previously ruled on SAIF's request for Board review. As noted above, jurisdiction rests with the court, not this forum. Thus, ORS 656.382(2) is not applicable. Moreover, even if the statute did apply, we have declined to reconsider our decision. Consequently, we have not made a finding "that the compensation awarded to a claimant should not be disallowed or reduced" as required by the statute to award such a fee.

Accordingly, SAIF's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 545 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
**DONALD E. BECK, Claimant**
WCB Case No. 91-01904
ORDER ON REVIEW
Michael B. Dye, P.C., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Black's order that upheld the self-insured employer's denial of medical treatment for claimant's neck, upper back, and headache conditions. On review, the issue is compensability of medical services. We affirm.

## 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's 1983 left shoulder injury was the result of a motorcycle accident and was not work related. (Ex. 5). Following his June 30, 1986 closing exam for his 1986 compensable left shoulder injury, claimant did not report any left shoulder problems to his treating physician, Dr. Davis, until January 1991, after he underwent an EMG, a diagnostic test performed for a noncompensable neck condition.

That EMG was a material cause of claimant's need for medical services regarding his left shoulder. The major cause was both injuries to claimant's left shoulder--the noncompensable 1983 injury and the compensable 1986 injury. (Ex. 48-29).

## CONCLUSIONS OF LAW AND OPINION

Relying in part on ORS 656.273(1), the Referee concluded that the medical services in question were not compensable because the worsening of claimant's left shoulder condition was caused in major part by an injury not occurring in the course and scope of employment, namely the EMG which was performed for claimant's noncompensable neck condition. Although we agree that claimant has not established compensability of his claim for medical services, we reach our conclusion based on the following analysis.

Claimant requested a hearing regarding the employer's January 16, 1991 partial denial relating to claimant's current condition. The employer had received several bills relating to treatment for neck, upper back and headache complaints. It denied that claimant's current care was related to his accepted left shoulder injury. At hearing, claimant's attorney stated that the issue was not an aggravation claim. (Tr. 6). Instead, he stated that the issue was the compensability of medical services that claimant received since November 7, 1990. (Tr. 5-7). He contended that these medical services were provided as a result of the compensable left shoulder condition and stated that claimant was not making a claim for his headache condition. Id. The Referee correctly stated the issue as framed by the parties as the "[c]ompensability of medical treatment beginning November 7, 1990, and continuing in January of 1991 in relationship to claimant's accepted 1986 left shoulder injury."

On review, claimant argues that, pursuant to ORS 656.273(1), claimant need only establish that his worsened condition is caused in material part by the compensable injury. He argues that, if the employer contends that the worsening is caused in major part by an injury not in the course and scope of employment, it is the employer's burden to prove that contention. Claimant contends that he has met his burden of proof whereas the employer failed to meet its burden.

Claimant's statement of the law regarding burden of proof in an aggravation claim case is correct. Roger D. Hart, 44 Van Natta 2189 (1992). However, claimant's claim is not for an aggravation; therefore, aggravation law is not applicable. As discussed above, the issue at hearing was limited to the compensability of medical services. To the extent that claimant attempts to raise aggravation as a new issue on review, we decline to address it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Claimant is entitled to medical services that result from his compensable left shoulder injury. ORS 656.245(1)(a). The question presented here is whether the need for treatment is causally related to the compensable injury. Interpreting ORS 656.005(7)(a)(A), the Court of Appeals held that the major contributing cause test only applies to a condition or need for treatment that is caused by a compensable injury, whereas the material contributing cause test still applies to a condition or need for treatment that is directly caused by an industrial accident. Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

Here, the evidence establishes that claimant's need for treatment regarding his left shoulder is caused by the effect a noncompensable diagnostic test had on his prior compensable and noncompensable left shoulder injuries. Thus, the need for treatment is not directly caused by the 1986 industrial accident. Therefore, claimant must establish that the compensable left shoulder injury is the major contributing cause of his need for treatment. Because this is a complex medical issue, the resolution of this issue turns largely on the 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).

On April 26, 1991, claimant was examined by the Western Medical Consultants. Their report relates claimant's medical treatment to the 1986 compensable left shoulder injury. (Ex. 46-4, -5). However, they were unaware of the previous 1983 noncompensable left shoulder injury and the aftermath of the EMG which caused claimant to seek treatment for his left shoulder after having not needed any treatment for more than four years. Because we find their opinion to be based on an incomplete history, we do not find it persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Davis, M.D., who treated claimant following his 1986 compensable left shoulder injury, provides the only other medical opinion regarding causation. After Dr. Davis' closing examination on June 30, 1986, claimant did not seek further medical treatment regarding his shoulder for more than four years. However, during most of this period, claimant received medical treatment for severe headaches. Claimant does not contend (and there is no medical evidence) that these headaches are related to the compensable left shoulder injury.

Claimant returned to Dr. Davis on November 7, 1990 with complaints of "knots" in his neck, pain down his left arm, and limited cervical motion. (Ex. 29-14). Dr. Davis opined that these symptoms were probably coming from a neck problem and were not a secondary consequence of the compensable shoulder condition. (Ex. 48-14). He opined that the neck problems were probably caused by degenerative disc disease or pressure on a nerve. (Ex. 48-16). Dr. Davis referred claimant to a neurologist who performed an EMG in an effort to diagnose the neck problem.

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); Daniel T. Miller, 44 Van Natta 1201 (1992). However, there is no medical evidence that the EMG was performed as a result of the industrial injury. The EMG was performed to rule out degenerative disc disease and pressure on a nerve, not to rule out the possibility of involvement of the compensable shoulder injury.

Claimant returned to Dr. Davis in January 1991 complaining of left shoulder pain, which was a different problem than that complained of in November 1990. (Ex. 48-16). At his deposition, Dr. Davis was first informed about claimant's 1983 noncompensable left shoulder injury. (Ex. 48-27, -28). After receiving this information, Dr. Davis opined that the combination of the EMG and claimant's prior left shoulder injuries caused the flare up of claimant's left shoulder symptoms and resulting need for treatment. (Exs. 48-29, -42). Dr. Davis concluded that both injuries, not the EMG, were the primary cause of the flare up in claimant's left shoulder. (Ex. 48-29). However, he was not able to give an opinion as to which injury was the major cause of the problems following the EMG. (Ex. 48-28).

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). Here, there are no persuasive reasons not to defer to Dr. Davis. He treated claimant following the compensable 1986 injury and is in the best position to judge whether claimant's current

need for treatment is related to that injury. Thus, on this record, claimant has failed to sustain his burden of proving the necessary causal connection between his compensable left shoulder injury and the treatment he received beginning on November 7, 1990.

The court's recent decision in Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993), does not alter our conclusion that claimant's current left shoulder condition is not compensable. In Ferguson, the court found that emergency room treatment was compensable under ORS 656.245 as continued medical treatment bearing a material relationship to a compensable carpal tunnel syndrome (CTS) condition. However, there, the claimant had fallen at home following a compensable CTS surgery and required emergency room treatment to resuture his surgical wound. Here, the diagnostic EMG, unlike the CTS surgery and resuturing in Ferguson, was unrelated to claimant's compensable condition. Therefore, Ferguson is distinguishable.

ORDER

The Referee's order dated April 30, 1992 is affirmed.

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February 9, 1993 Cite as 45 Van Natta 181 (1993)

In the Matter of the Compensation of
**JAMES E. GLENN, Claimant**
WCB Case No. 92-00612
ORDER ON REVIEW
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband, Brazeau, and Gunn.

Claimant, pro se, requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of his claim for an inguinal hernia. On review, the issue is compensability.

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

With his brief, claimant has submitted an additional medical report from Dr. Oehling. We treat the submission of this additional evidence as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). The Board's review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine 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 hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Moreover, there has been no showing that Dr. Oehling's opinion was not obtainable with due diligence at the time of hearing. Accordingly, the motion to remand is denied.

ORDER

The Referee's order dated April 3, 1992 is affirmed.

**Board Member Gunn dissenting:**

I disagree with my distinguished colleagues and find that claimant has proven that his inguinal hernia was caused, in major part, by lifting activities at work.

Claimant initially sought treatment for the hernia from Dr. Bates, D.O.; however, he was referred for surgical intervention to Dr. Oehling, who became claimant's treating physician for the hernia condition.

The evidence regarding causation of the hernia is provided by Drs. Bates and Oehling. Dr. Bates opined that the etiology for the inguinal hernia was unknown, although it could have been done at work if claimant was lifting heavy objects there. There is no dispute that claimant's work required lifting heavy cases of copy paper. However, Dr. Bates' opinion does not meet claimant's burden of proof because it creates only a possibility that work activities caused the hernia.

On the other hand, I find that Dr. Oehling's opinions, as a whole, establish that claimant's hernia was caused by his lifting activities at work. Dr. Oehling repeatedly states that claimant's symptoms are within a diagnosis of a hernia caused by lifting at work and ultimately concludes that the hernia is work related. (Exs. 6, 7, 8, 9). Although Dr. Oehling does not use the words "major contributing cause;" no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Furthermore, the Board generally gives greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). I find no reason not to defer to Dr. Oehling's opinion.

Because I find that Dr. Oehling's opinions establish the compensability of claimant's hernia condition, I respectfully dissent.

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February 9, 1993 Cite as 45 Van Natta 182 (1993)

In the Matter of the Compensation of
**GERALD K. HALE, Claimant**
WCB Case No. 90-07637
ORDER OF ABATEMENT
Parks & Ratliff, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our January 11, 1993 Order on Review. Specifically, SAIF contends that: (1) we failed to permit supplemental briefing in accordance with our August 26, 1992 Interim Order (remanding) before proceeding with our review ; (2) we failed to address a procedural issue involving an open Arizona claim for claimant's left shoulder; and (3) we did not apply the major contributing cause standard consistent with the court's recent holding in Textronix, Inc. v. Nazari, 117 Or App 409 (1992).

SAIF accurately notes that we neglected to establish a supplemental briefing schedule. In light of such circumstances, we withdraw our January 11, 1993 order and implement the following supplemental briefing schedule.

Both parties' supplemental briefs regarding any and all issues raised in this case shall be due within 21 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GREGORY A. JOHNSON, Claimant**
WCB Case No. 91-16881
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Menashe's order that: (1) upheld the insurer's denial of claimant's medical services claim for a low back condition; and (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant's industrial accident in 1988 is a material contributing cause of his current low back condition and resulting need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current low back condition is not compensable, finding that claimant had not proved that his 1988 compensable injury was a material contributing cause of the current back condition. We disagree.

On June 1, 1988, claimant sustained various compensable injuries, including a lumbar sprain/strain, when he fell 10 feet from a ladder and landed on his back. (Tr. 10-11; Exs. 2, 5). The claim was accepted as a nondisabling injury. Claimant treated conservatively with Dr. Forgey, D.C., for various symptoms, including low back pain, until July 25, 1989. (Ex. 25).

Sometime thereafter, claimant treated a couple of times with a chiropractor in Chicago for low back instability. (Tr. 13). He then moved to Minnesota and, during the weekend of August 17, 1991, he helped his brother and his brother's employees dismantle his uncle's garage; that work involved stacking sheets of plywood, hauling lumber to trucks, pulling nails and sweeping. (Tr. 14-15; Ex. 14A). He did not experience any low back injury while performing that work. (Tr. 15).

On August 21, 1991, claimant saw Dr. Rusoff, D.C., for pain in the low back, right hip and left leg. (Exs. 11, 12). Dr. Rusoff referred claimant to Dr. Anderson, M.D. An MRI scan revealed degenerative disc disease from L3 through S1 with disc herniations at L3-4 and L4-5. (Ex. 17). Claimant filed a claim for medical services, which was denied by the insurer. (Ex. 22).

Claimant's low back condition is compensable if he sustains his burden of proving that the 1988 industrial accident was a direct and material contributing cause of that condition. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992); Suzanne Day-Henry, 44 Van Natta 1792 (1992). Because more than three years had elapsed between the June 1988 accident and the onset of the current condition in August 1991, the causation issue presents a complex medical question which must be resolved largely on the basis of expert medical opinion. 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).

Dr. Anderson opined that the 1988 injury is "the most significant contributing factor to the ongoing pain and the need for further treatment." (Ex. 26). Dr. Rusoff opined:

> "It is my opinion that [claimant] has sustained his low back impairment as a direct result of the 6-1-88 work injury, and that his fall was the primary contributing cause of his present low back condition. It must be acknowledged that there is no

absolute and objective method for determining the exact moment that this back injury occurred, however, the objective degeneration that is presently evident in his low back appears to be at least several years old. In addition, [claimant] has no history of other major work, sports or automobile accidents that are likely to have caused these problems." (Ex. 27-2).

Dr. Cheng, a neurologist who conducted an independent medical examination, opined:

"As far as the etiology for this [current low back condition], I think it is possible for the [June 1988] fall to cause this disc herniation, even though [Dr. Forgey's] records do not show findings of radicular symptoms nor does he record any neurologic findings consistent with a disc herniation. There is no objective evidence to document the presence of a disc herniation in 1988 or 1989 and I have no evidence that any underlying degenerative condition or disc herniation has worsened since then. Assuming that he had no radiating pain until the Monday or Tuesday following his weekend of moving lumber with subsequent back pain and pain into the buttock, it would be my opinion that this incident was a material contributing factor in his reported symptoms." (Ex. 24-4).

The Referee found Dr. Cheng's opinion to be better reasoned and based on a more complete history than the other opinions. Relying on Cheng's opinion, the Referee concluded that claimant had not sustained his burden of proof. We disagree with that analysis.

We find Dr. Rusoff's opinion to be well-reasoned and based on accurate and complete information. Although Rusoff apparently did not have access to all of the June 1988 medical records to which Dr. Cheng had access, Rusoff had sufficient information to determine that claimant's degenerative condition is several years old and that there is no evidence of any other low back injury besides the June 1988 injury. Those facts, which are not controverted, support his opinion that the 1988 injury is the direct and primary cause of the current low back condition. Moreover, Rusoff had a complete history of claimant's activities in helping to dismantle his uncle's garage. (See Ex. 14A; Tr. 27). Accordingly, we find Rusoff's opinion to be persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Furthermore, Rusoff's opinion is supported by Dr. Anderson and, contrary to the Referee's implied finding, is not contradicted by Dr. Cheng. Cheng conceded, in fact, that it was "possible" for the 1988 injury to have caused the current condition, even in the absence of radicular or neurologic findings of a disc herniation in 1988. (Ex. 24-4). Additionally, Cheng's opinion that claimant's activities in helping to dismantle his uncle's garage is a material contributing cause of his condition does not contradict Rusoff's and Anderson's opinions that the 1988 injury is the "primary" or "most significant" cause.

Based on the aforementioned analysis, we find that the 1988 industrial accident is a direct and material contributing cause of claimant's current disability and need for treatment. Alternatively, if claimant's current condition was analyzed as a "consequence" of the 1988 injury, the aforementioned evidence would sustain claimant's burden of proving that the injury is the major contributing cause of the consequential condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

Penalties and Attorney Fees

In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability at the time of its denial. If the insurer did not have such doubt, the denial is unreasonable. See Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "legitimate doubt" must be evaluated on the basis of the information available to it at the time of the denial. Id.

Here, the insurer issued its denial on November 14, 1991. At that time, the only medical reports in existence were from Drs. Rusoff and Anderson, all of which supported the compensability of the claim. (See Exs. 15, 18, 19). The insurer did not have any medical evidence to the contrary, nor was the insurer aware that claimant had been working on his uncle's garage during the weekend of August 17, 1991. Under these circumstances, we find that the insurer did not have a legitimate doubt of its liability for the claim. Accordingly, the denial was unreasonable. See id. The insurer is assessed a penalty in the amount of 25 percent of all amounts of compensation due as of the date of hearing as a

result of this order. See ORS 656.262(10)(a); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). The penalty shall be paid in equal shares to claimant and his attorney.

Claimant also seeks the assessment of a separate attorney fee for the insurer's unreasonable denial. However, because the attorney fee is sought on the same factual basis for which we have assessed a penalty, we have no authority to assess the attorney fee. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,500, 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 appellate briefs, 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 March 20, 1992 is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. The insurer is assessed a penalty equal to 25 percent of all amounts of compensation due as of the date of hearing as a result of this order, with equal shares payable to claimant and his attorney. Claimant's attorney is awarded an assessed attorney fee of $3,500 for services at hearing and on review, payable by the insurer.

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February 9, 1993 Cite as 45 Van Natta 185 (1993)

In the Matter of the Compensation of
**DAVID L. JONES, Claimant**
WCB Case No. 91-06745
ORDER OF ABATEMENT
Malagon, Moore et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our January 13, 1993 order which reversed that portion of a Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant seeks abatement of our order so that we can retain jurisdiction over this matter to consider the parties' proposed settlement. (Parenthetically, we note that the Supreme Court has denied review of the Court of Appeals' decision in SAIF v. Herron, 114 Or App 64 (1992). 315 Or 271 (1992).)

In light of such circumstances, we withdraw our January 13, 1993 order. Upon receipt of the parties' proposed agreement, we will proceed with our review. The parties are requested to keep us fully apprised of further developments concerning this case.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEORGE A. LACHAPELLE, Claimant**
WCB Case No. 91-11975
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Westerband.

The self-insured employer requests review of Referee Thye's order that increased claimant's unscheduled permanent disability for a right shoulder injury from 16 percent (51.2 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but we do not adopt the Referee's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The sole issue raised on review is whether claimant is entitled to a value for adaptability under the standards. Based on restrictions placed on claimant by the attending physician after the date of the Notice of Closure, the Referee found that claimant returned to modified work and was, therefore, entitled to values for adaptability and the other non-impairment factors.

In its appellant's brief, the employer asserts that claimant is not entitled to a value for adaptability because at the time of determination, claimant had been released by his attending physician to regular work. We agree.

Subsequent to the date of the Referee's order, we issued our decision in Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992). In that case, we concluded that adaptability should be rated at the "time of determination." We based our conclusion on former OAR 436-35-310(1)(a), which states that the impact for the factor of adaptability "is based upon the worker's work status at and before the time of determination[.]" "Time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (now section (12)).

In Heather I. Smith, 44 Van Natta 2207 (1992), we reaffirmed our decision in Libel. In Smith, we acknowledged that ORS 656.283(7) provides that disability is evaluated at the time of the reconsideration order, but we concluded that the intent of ORS 656.283(7) was to permit consideration of a medical arbiter's report during the reconsideration proceeding, not to allow one party to establish that one of the factors involved in determining disability had changed since the claim was closed. We found additional support for our decision in Smith in ORS 656.268(5), which has been interpreted not to allow submission of evidence of post closure changes in a claimant's condition. See e.g. Grace M. Nyburg, 44 Van Natta 1875 (1992); George Schukow, 44 Van Natta 2125 (1992).

Here, claimant's claim was closed by Notice of Closure dated April 30, 1991. Former OAR 436-35-270 through 436-35-450 apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Order 2-1991. We rate claimant's adaptability according to claimant's work status at and before the mailing date of the Notice of Closure. At the time of closure, claimant's attending physician had released him to his regular work as a truck driver with a suggestion that claimant drive only trucks with power steering. Regular work is defined in former OAR 436-35-270(3)(c) as "substantially the same job held at the time of injury, or substantially the same job for a different employer." We find, based on the record, that claimant had been released to regular work at the time of closure. Accordingly, he is not entitled to a value for adaptability. Former OAR 436-35-310(2).

On July 1, 1991, claimant's attending physician indicated that claimant had modifications in that, ideally, claimant should drive a truck with an automatic transmission and lift less than 40 pounds. We find that these limitations, placed on claimant after the date of closure, are not relevant in determining claimant's status at the time of closure. Heather I. Smith, supra.

The parties have stipulated that claimant's loss of range of motion entitles him to an award of 9 percent and his surgery to an award of 5 percent. Accordingly, claimant's unscheduled permanent disability under the standards is 14 percent.

ORDER

The Referee's order dated January 31, 1992 is modified. In lieu of the Referee's increased award and the Order on Reconsideration, claimant is awarded 14 percent (44.8 degrees) unscheduled permanent disability.

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In the Matter of the Compensation of
**STEVE A. McCALISTER, Claimant**
WCB Case No. 91-11053
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Kinsley.

Claimant requests review of those portions of Referee Brown's order that: (1) found that claimant's back injury claim was not prematurely closed; (2) upheld the insurer's denial of claimant's aggravation claim; and (3) found that the Hearings Division lacked jurisdiction to address the medical services dispute. On review, the issues are jurisdiction, premature closure and, if the claim was not prematurely closed, aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following modification and supplementation.

As of May 7, 1991, claimant's condition was not reasonably expected to materially improve, either with additional medical treatment or the passage of time.

Claimant's compensable back condition worsened, at least symptomatically, between May 7, 1991 and May 16, 1991, such that claimant was less able to work on May 16, 1991 than he was on May 7, 1991. This worsening is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant argues that the effect of the insurer's June 18, 1991 denial was to deny additional substantive medical services, thereby investing jurisdiction in the Hearings Division. We disagree.

The insurer's denial is premised on the insurer's assertion that claimant exceeded the number of attending physicians allowable without its prior approval. See OAR 436-10-060. Because original jurisdiction over such disputes lies exclusively with the Director, we agree with the Referee's conclusion that he lacked authority to address the propriety of the insurer's denial. See James B. Palmer, 43 Van Natta 2803 (1991); Tracy Johnson, 43 Van Natta 2546 (1991).

Premature closure

We agree with and adopt the Referee's opinion on this issue as supplemented herein.

It is claimant's burden to prove that he was not medically stationary as of the date his claim was closed. See ORS 656.268(1); ORS 656.005(17); Berliner v. Weyerhaeuser Co., 54 OR App 624 (1981). Claimant's assertion that his claim was prematurely closed relies on the opinion of Dr. Conwell, as well as the physical therapy treatment prescribed by him. We find, however, that Dr. Conwell's treatment, as well as his medical opinion, relate to a time period after claimant's claim was closed. Conwell did not and, in his opinion, could not comment regarding whether claimant was medically stationary as of May 7, 1991, the date of claim closure. Evidence regarding post-closure changes in claimant's condition is not relevant to our inquiry. See Schuening v. I.R. Simplot Co., 84 Or App 622 (1987).

Aggravation claim

On this issue, the Referee stated, "With regard to the aggravation claim, there is none." (O&O p. 3). We disagree.

On May 16, 1991, claimant's attorney requested that the insurer commence payment of temporary disability benefits for claimant and provided the insurer with a copy of Dr. Conwell's note of the same date releasing claimant from work. (See Ex. 4A). The insurer does not contend that it failed to receive this faxed transmission.

In our view, the off-work notice and the request for temporary disability benefits constituted a claim for an aggravation under ORS 656.273(2). See Herman Carlson, 43 Van Natta 963, 964 n. 1 (1991) aff'd on other grounds, Carlson v. Valley Mechanical, 115 Or App 371 (1992). Accordingly, we proceed to consider whether claimant has proven his aggravation claim.

In order to establish a compensable aggravation, claimant must prove that his back condition worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. See 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 worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1). In addition, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8).

When Dr. Conwell examined claimant on May 16, 1991, he recorded objective findings including paraspinous muscle spasm, tenderness to palpation and percussion and decreased tendon reflexes. (Ex. 4-2). On August 26, 1991, Conwell opined that claimant was not medically stationary as of the May 16 examination and noted that Dr. Grant's objective findings at the February 6, 1991 closing examination "differed substantially" from those recorded by Conwell on May 16. Moreover, when claimant became medically stationary in February 1991, Grant released him to all but heavy work. After the claimed worsening, on the other hand, Conwell released claimant from all work as of May 16, 1991. Under these circumstances, we conclude that claimant has proven, by medical evidence supported by objective findings, that his compensable back condition has worsened such that claimant is less able to work than he was as of the May 7, 1991 Determination Order. Finally, there is no evidence that the May 1991 Determination Order, which awarded 3 percent permanent disability, contemplated waxing and waning of symptoms. Claimant proved a compensable aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. 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 aggravation issue is $800, 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 appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 16, 1992 is affirmed in part and reversed in part. That portion of the order that upheld the insurer's denial of claimant's aggravation claim is reversed. The denial is set aside and the claim is remanded to the insurer for further processing according to law. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded an $800 attorney fee, payable by the insurer.

In the Matter of the Compensation of
**MICHELLE A. NUGENT, Claimant**
WCB Case No. 91-16332
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Brazeau.

Claimant requests review of Referee Livesley's order that upheld the insurer's denial of claimant's occupational disease claim for a mental condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

Claimant is a certified vocational counselor. In July 1988, she began working for Norm Peterson and Associates, a vocational counseling firm with offices in Eugene and Ashland. Claimant became a share holder and served as Corporate Vice-President and Vice-Chair of the Board of Directors. She also managed the Eugene office, while Norm Peterson managed the Ashland office.

In July 1990, claimant received an unpaid bill from Kelly Temporary Services for $3,000. Because the corporation hired Kelly temporaries for office personnel, claimant believed that the bill should have previously been paid with payroll. When she asked Peterson for an explanation, he stated that he had considered the bill as a low priority operational expense, because Kelly pays all federal and state taxes on the earnings of its employees. He further stated that he had not paid the bill simply because they had not yet demanded payment and that things were not going well financially.

Claimant subsequently met with Peterson to discuss the corporation's finances. During the meeting, she became upset at Norm Peterson and, among other things, questioned the propriety of his use of the corporation's American Express card to pay for weekly business lunches. She later reviewed the corporate records and determined that accounts payable exceeded accounts receivable. Claimant had been provided with monthly financial statements, but did not fully understand them. She also discovered that sales and marketing costs were split evenly between the two offices, but that the revenue was disproportionately credited to the Ashland office.

After examining the corporate records, claimant took a vacation, during which she discovered that Peterson had taken some unused office equipment and supplies from the Eugene office for use in the Ashland office. Although Peterson had previously discussed the need and intent to do so, claimant became upset and scheduled an appointment with Dr. Carl Peterson, a psychologist with whom she had sought intermittent treatment since 1984. Dr. Peterson noted that claimant was experiencing anxiety and diagnosed an adjustment disorder with mixed emotional features and work inhibition, as well as a major depressive episode.

Through counseling, claimant determined that her work situation with Norm Peterson and Associates was detrimental and she resigned on September 15, 1990. On July 24, 1991, she filed a claim seeking compensation for disability and medical services related to her mental condition. On November 19, 1991, claimant was examined by Dr. Holland, a psychiatrist, at the insurer's request. Based on Holland's report, the insurer denied the claim on October 1, 1991. Claimant subsequently requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to establish the compensability of her mental disorder as an occupational disease under ORS 656.802(3) and, accordingly, upheld the insurer's denial. We agree with the Referee's conclusion, but offer the following analysis.

ORS 656.802(3) provides, in part:

> "Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> "* * * * *

> "(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." (Emphasis supplied.)

In Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991), the court concluded that, by adding the emphasized language, the legislature intended to preclude claims for mental disorders that arose from conditions common to all employments.

In this case, the stressors identified by claimant predominately concern her impression that Peterson was making inappropriate business decisions impacting on the future of the corporation. While we understand claimant's concern about the viability of the business, we conclude that those stressors are generally inherent in every working situation. As noted by the Referee, the fear over the failing of a business enterprise is common to all employments. Moreover, while claimant may have had a legitimate basis for disagreeing with Peterson's management decisions, we accept Peterson's explanation for those decisions and do not agree with claimant that Peterson's decisions were so unreasonable as to remove them from the range of "generally inherent" conditions.

In short, even if we assume that there is evidence in the record to support a finding that the other requirements of an occupational disease claim are met, we conclude that claimant has failed to establish that the employment conditions producing the alleged mental disorder are conditions other than conditions generally inherent in every working situation. Accordingly, we conclude that claimant has failed to establish the compensability of her mental condition as an occupational disease.

ORDER

The Referee's order dated March 24, 1992 is affirmed.

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In the Matter of the Compensation of
**JANET A. ROBBINS, Claimant**
WCB Case No. 91-08231
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
VavRosky et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's occupational disease claim for Morton's neuroma. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Given the repetitive nature of claimant's work activities, we analyze her occupational disease claim under ORS 656.802(1)(c). Claimant must prove that work activities were the major contributing cause of the Morton's neuroma or its worsening. See ORS 656.802(2). A worsening of symptoms alone is not sufficient unless the medical evidence establishes that the manifested symptoms are the disease. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia-Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

The Referee was not persuaded that work activities were the major contributing cause of either the onset or worsening of Morton's neuroma. Nevertheless, finding that work activities were the major contributing cause of the neuroma becoming symptomatic, and reasoning that those symptoms are the disease, the Referee concluded that claimant had sustained her burden of proving a compensable occupational disease. We disagree.

Warren and Vorderstrasse are distinguishable from this case. In Warren, the court found that the carpal tunnel syndrome for which the claimant was seeking compensation was a complex of symptoms and that there was no distinction drawn between the syndrome and any underlying carpal tunnel disease. Accordingly, the court concluded that the symptoms were the disease. 103 Or App at 278-79. In Vorderstrasse, the court found that the Raynaud's Phenomenon for which the claimant was seeking compensation was only made manifest by the symptoms giving rise to the claim. Again, the court concluded that the symptoms were the disease. 104 Or App at 501-502.

Here, Dr. Pribnow provided the only opinion concerning the causation of the neuroma. By deposition, Pribnow explained that Morton's neuroma is an enlargement of a nerve to the toes which is located between metatarsal bones in the foot. He added that walking may irritate the enlarged nerve causing numbness and a burning sensation in the toes. (Ex. 8-5). He opined that the neuroma itself is caused by a major trauma or recurrent irritation, but not by excessive walking. (Ex. 8-6).

At one point in his deposition, Pribnow stated that the neuroma symptoms are the condition; however, he later clarified his opinion to state that the symptoms "indicate" the condition. (See Ex. 8-9, 8-27). He stated that the neuroma is a palpable mass and that it is possible to have a neuroma without symptoms. (Ex. 8-16, 8-23). He explained that the neuroma does not produce symptoms if it is too small or there is no activity to cause irritation to the nerve. (Ex. 8-23).

Thus, Pribnow persuasively distinguishes the neuroma itself from the symptoms arising from irritation to the enlarged nerve. He also establishes that the neuroma is more than a complex of symptoms; it is a palpable mass which exists whether or not there are symptoms. Accordingly, we do not find that claimant's symptoms are the disease for purposes of establishing its compensability.

Therefore, claimant must prove that work activities were the major contributing cause of the neuroma or its pathological worsening. Because this issue presents a complex medical question, its resolution turns largely on the 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).

Dr. Pribnow did not believe that work activities were the major factor in the development of the neuroma. (Ex. 8-11). He felt that claimant's off-work activities as a runner and skier were more likely causes of the neuroma. (Id.) Pribnow was unable to state whether work activities caused a worsening of the underlying neuroma. He stated that a worsening of symptoms did not mean that the neuroma itself had expanded. (Ex. 8-25 through 8-28).

Based on our review of the record, particularly the medical evidence, we are not persuaded by a preponderance of the evidence that claimant has sustained her burden of proof. See ORS 656.266. Accordingly, we conclude that her claim is not compensable.

## ORDER

The Referee's order dated May 28, 1992 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

In the Matter of the Compensation of
**CHRISTINE SUTTON, Claimant**
WCB Case No. 91-13948
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee McWilliams' order that: (1) declined to award additional temporary partial and total disability; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary partial disability, temporary total disability, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Partial Disability

The Referee found that claimant had been declared medically stationary and released to work without restriction on December 10, 1990. Consequently, the Referee concluded that claimant was not entitled to temporary partial disability benefits from April 12, 1991 through September 2, 1991. We disagree.

On February 22, 1991, Referee Livesley set aside the SAIF Corporation's denial of claimant's December 1989 neck and left shoulder injury claim. The claim was remanded to SAIF for processing in accordance with law. SAIF appealed the Referee's order, but also began paying temporary total disability subsequent to the Referee's order. Those benefits were terminated on April 12, 1991, when claimant began modified employment. SAIF based its termination of temporary disability on a December 10, 1990, release for work from Dr. Campagna.

Pursuant to ORS 656.268(3), temporary disability 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. See Soledad Flores, 43 Van Natta 2504 (1991).

Here, SAIF contends that it was authorized to terminate claimant's temporary disability in April 1991 because of Dr. Campagna's December 1990 release to return to work. Claimant disagrees with SAIF's characterization of Dr. Campagna as an attending physician. We need not resolve that dispute for purposes of this issue because even if Dr. Campagna was claimant's attending physician, the December 10, 1990 release would not satisfy ORS 656.268(3)(b).

Dr. Campagna released claimant to work, but did not indicate whether the release was applicable to regular or modified work. Moreover, although Campagna noted that claimant was "looking for work," neither the specific work activities nor potential employment were mentioned. Finally, Dr. Campagna concluded that claimant had suffered mild impairment as a result of her compensable injury.

In light of such circumstances, we are not persuaded that Dr. Campagna's release constitutes a written release to return to regular employment. Consequently, such a release would not authorize SAIF to terminate claimant's temporary disability. ORS 656.268(3)(b).

On claimant's April 12, 1991 return to modified employment, SAIF was authorized to terminate temporary total disability. See ORS 656.268(3)(a). Nevertheless, SAIF was likewise obligated to begin paying temporary partial disability. OAR 436-60-030(3). Such benefits must be computed in accordance with OAR 436-60-030(1). If claimant's wages in the modified employment were equal to or greater than her wages earned at the time of her injury, her temporary partial disability would be zero. OAR 436-60-030(2). Inasmuch as claimant's work was part-time (approximately 3 to 4 hours a day), claimant's temporary partial disability payments would exceed zero. Accordingly, we conclude that claimant was procedurally entitled to temporary partial disability benefits from April 12, 1991 through September 2, 1991.

Relying on Thomas W. Lundy, 43 Van Natta 2307 (1991), SAIF also argues that it was not required to pay temporary partial disability. Lundy does not control this situation. In Lundy, we held that temporary partial disability was not payable because the claimant had been released to full duty work activities. We reasoned that although ORS 656.268(3) does not expressly authorize the unilateral termination of temporary partial disability, as distinct from temporary total disability, a carrier may terminate temporary partial disability when a claimant has been released for regular work. Id. at 2309. Here, we have found that claimant was not released for regular work, but rather, began performing modified work. Accordingly, the Lundy holding is not applicable.

Temporary Total Disability

The Referee further concluded that, although claimant was entitled to a resumption of temporary total disability benefits beginning September 3, 1991, SAIF was not obligated to pay such benefits under ORS 656.313(1). The Referee relied on Walden J. Beebe, 43 Van Natta 2430 (1991). We disagree with the Referee's reasoning.

The filing of an appeal by a carrier stays payment of the compensation appealed, except for 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. ORS 656.313(1)(a)(A); Walden J. Beebe, supra. In Beebe, supra, we held that a carrier is permitted to stay the payment of temporary disability benefits owing prior to the appealed order. However, we further determined that a carrier was required to provide temporary disability accruing after the date of the appealed order until proper claim closure or reversal of the appealed decision.

Here, SAIF appealed Referee Livesley's February 22, 1991 order. Under ORS 656.313(1), its appeal stayed payment of any temporary disability benefits owing prior to that time. Nevertheless, the disputed temporary total disability benefits pertain to a period (September 3 - September 23, 1991) accruing after the appealed February 22, 1991 order. Accordingly, such benefits could not be stayed pursuant to ORS 656.313(1)(a)(A).

SAIF acknowledges that the "stay" provisions of ORS 656.313 are not applicable. Nonetheless, it asserts that it was not required to recommence temporary total disability on September 3, 1991 because such disability was not authorized by claimant's attending physician. We are not persuaded by SAIF's argument.

Temporary partial disability shall continue until the attending physician verifies that the worker cannot continue working and is again temporarily totally disabled. OAR 436-60-030(4)(a). Attending physician means a doctor or physician as defined in ORS 656.005(12) who accepts primary responsibility for the treatment of a worker's compensable injury. OAR 436-60-005(2).

Dr. Johnson retroactively authorized temporary total disability from September 3, 1991. SAIF argues that it properly resumed the payment of temporary total disability as of September 23, 1991, the date retroactively authorized by Dr. Campagna. In this regard, it asserts that Dr. Campagna, not Dr. Johnson, was claimant's attending physician.

Based on Referee Livesley's February 22, 1991 order, Dr. Johnson was claimant's treating physician at that time. (Ex. C). The order expressly refers to Dr. Johnson as the "treating physician" and finds that Johnson authorized time loss. Moreover, at the January 1992 hearing in this case, although she also recognized that Dr. Campagna had recently released her to work, claimant testified that Dr. Johnson was her "treating physician." (Tr. 8). Dr. Campagna performed cervical surgery in July 1990 and October 1991, as well as conducted periodic reexaminations. Yet, despite rendering opinions on claimant's work capacity and permanent impairment, Dr. Campagna also recognized that claimant was still receiving treatment from Dr. Johnson. (Ex. 2 - May 1991 Supplemental Report).

Considering the findings rendered in Referee Livesley's February 1991 order and claimant's overall testimony in this case, as well as the aforementioned acknowledgment from Dr. Campagna, we find that Dr. Johnson was primarily responsible for the treatment of claimant's compensable injury. Consequently, we conclude that Dr. Johnson was claimant's attending physician. ORS 656.005(12); OAR 436-60-005(2). Inasmuch as Dr. Johnson authorized the payment of temporary total disability beginning September 3, 1991, we conclude that SAIF was procedurally obligated to pay such benefits. OAR 436-60-030(4)(a).

Penalties

The Referee declined to assess a penalty or related attorney fee for SAIF's allegedly unreasonable failure to pay temporary disability benefits. We conclude that penalties are assessable.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's actions must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, SAIF terminated temporary total disability and failed to begin paying temporary partial disability when claimant returned to modified employment in April 1991. As support for this conduct, SAIF relied on Dr. Campagna's December 1990 release to work. As noted above, even assuming that Dr. Campagna could be considered claimant's attending physician, the release did not expressly authorize claimant to return to "regular work." In fact, based on Campagna's references to mild impairment, it is questionable whether the release was issued without restrictions. In any event, SAIF's termination of temporary total disability and failure to pay temporary partial disability was not triggered until claimant's April 1991 return to modified employment.

Since SAIF did not provide temporary partial disability beginning with claimant's April 1991 return to modified work, we find its conduct to have been unreasonable. Consequently, we assess a penalty equal to 25 percent of the temporary partial disability due between April 12, 1991 and September 2, 1991. ORS 656.262(10)(a). One-half of this penalty shall be awarded to claimant's counsel in lieu of an attorney fee. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

We also find SAIF's failure to recommence temporary total disability on September 3, 1991 to have been unreasonable. Although Dr. Campagna had performed claimant's surgeries, there was no indication that claimant was no longer treating with Dr. Johnson or that she wished to transfer the primary responsibility for her care from Dr. Johnson to Dr. Campagna. For this unreasonable conduct, SAIF is assessed a penalty equal to 25 percent of the temporary total disability due between September 3, 1991 and September 23, 1991. ORS 656.262(10)(a). Once again, one-half of this penalty shall be awarded to claimant's counsel in lieu of an attorney fee. See Martinez v. Dallas Nursing Home, supra.

Claimant also seeks a carrier-paid fee for SAIF's unreasonable conduct under ORS 656.382(1). Yet, 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, a separate attorney fee award is not assessable. Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, supra.

Here, claimant asserts that the factual bases for SAIF's unreasonable conduct are different in that SAIF failed to pay temporary partial disability on her April 1991 return to modified employment and subsequently failed to recommence temporary total disability as of September 3, 1991 pursuant to Dr. Johnson's authorization. Without question, these are different acts. Nevertheless, there are separate amounts of compensation which were unreasonably resisted as a result of those acts. Specifically, the temporary partial disability that SAIF failed to pay between April 12, 1991 and September 2, 1991, and the temporary total disability that SAIF failed to provide between September 3, 1991 and September 22, 1991. Since there are distinct sums "then due" on which to assess a penalty for each of SAIF's separate and unreasonable acts, we are not authorized to assess a separate attorney fee under ORS 656.382(1) for that same conduct.

ORDER

The Referee's order dated March 26, 1992 is reversed. The SAIF Corporation is directed to pay claimant temporary partial disability benefits from April 12, 1991 through September 2, 1991 and temporary total disability benefits from September 3, 1991 through September 23, 1991. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Additionally, SAIF is directed to pay to claimant as penalties for its unreasonable conduct 25 percent of the temporary disability awarded by this order. These penalties are to be divided equally between claimant and her attorney.

In the Matter of the Compensation of
**MEGAN L. ASHBAUGH, Claimant**
WCB Case No. 91-04941
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of that portion of Referee Crumme's order that upheld the SAIF Corporation's partial denial of her low back condition. Claimant also contends that the Referee erred in refusing to admit x-ray reports that were submitted after the hearing. We view claimant's contention as a motion for remand. On review, the issues are remand and compensability.

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

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. ORS 656.295(5). To merit remand, claimant must show that the evidence relevant to the issues raised in the request to remand was unobtainable with due diligence before the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

Claimant seeks to admit x-ray reports dated in September 1986, which she obtained after the July 16, 1991 hearing. At hearing, claimant's attorney explained that the x-ray reports were requested from a hospital in California the week previous to the hearing and had not yet arrived. Claimant requested that the record be left open for those reports. The Referee denied the request. (Tr. 3-4). We agree with the Referee's decision. Claimant has offered no reasonable explanation for her delay in obtaining the reports. Accordingly, we are unable to find that the reports were previously unobtainable with due diligence. We decline to remand this matter for further evidence taking.

ORDER

The Referee's order dated August 15, 1991, as reconsidered September 20, 1991, is affirmed.

**Board Member Hooton dissenting.**

In this case the majority affirms and adopts the findings of fact and reasoning of the Referee with some minimal supplementation involving the claimant's request to remand for the admission of medical reports in existence since September of 1986 but unobtained at the time of hearing. The additional argument does not affect the reasoning or findings of the Referee based on the evidence presented at the time of hearing. I agree with the additional remarks of the Board on the issue of remand. However, I am unable to conclude on the present record that claimant suffered from a preexisiting low back condition, or that the medical record supports the Referee's conclusion that claimant's memory was "faulty." Indeed the findings of the Referee are not supported by substantial evidence in the record as a whole, and his reasoning is inconsistent with his findings. Therefore, I must dissent.

Claimant contends that her electric shock injury of November 30, 1987 caused injury to her neck, right shoulder and upper arm. She received treatment for those conditions from Dr. Brittain, and others. She contends that she experienced no symptoms in her low back until her first treatment with Dr. Simonson, a California based chiropractor, on June 7, 1988. She contends that her low back condition, including a herniated disk at L5-S1 and chronic lumbar strain/sprain, is compensable since it arose from the treatment rendered by Dr. Simonson for her compensable neck and right shoulder conditions.

The insurer contends that the low back condition preexisted the injury of November 30, 1987 and was not worsened by that injury or by the subsequent chiropractic manipulations rendered in treatment of her compensable neck and shoulder conditions. Consequently, the insurer contends that the low back condition is not a compensable consequence of her November 30, 1987 injury.

Dr. Woolpert, an independent medical examiner upon whom the insurer principally relies, acknowledges that Dr. Simonson's chiropractic adjustments could have increased preexisting low back symptoms, or have actually caused the disk herniation. (Ex. 35.) Dr. Thompson, claimant's current treating physician, argues that claimant's current low back condition was actually caused by Dr. Simonson's chiropractic manipulations. (Exs. 27 and 34A.) Consequently, claimant's contentions are not beyond the realm of medical probability. Dr. Woolpert ultimately concludes that the better explanation is that claimant experienced a preexisting low back condition which became aggravated independent of her November 30, 1987 injury, and that the preexisiting condition is the major contributing cause of her current low back complaints. The real question presented for resolution, therefore, is whether claimant had a preexisting low back condition, or whether her current condition arose on June 7, 1988, as the claimant contends. Resolution of that question necessarily determines which of the two competing medical experts offers the more reliable explanation of causation.

The Referee made specific findings which bear upon the question presented. These findings are as follows:

> "1. In September 1986, claimant developed low back pain after her back hurt from bicycling and a friend "cracked her back" in an effort to help. She subsequently received chiropractic treatment for this condition for several months. Her symptoms resolved. (Ex. 34A-1.)
>
> "2. On October 22, 1987, claimant suffered a lumbar strain from lifting during the course of her work for employer. Her symptoms from this condition resolved. (Ex. 34A-1.)
>
> "4. Initially after the November 30, 1987 work injury, claimant suffered pain in her upper arm, shoulder, and neck. However, through April 13, 1988, her symptoms did not include low back pain. (Exs. 1,33, and 34.)
>
> "14. "Claimant's November 30, 1987 work injury has not contributed to her disability and need for treatment relating to her low back, either directly or indirectly. Her current low back condition is due to a combination of, first, conditions that preexisted her November 30, 1987 work injury and, second, chiropractic adjustments to the low back that she received subsequent to the November 30, 1987 injury. The chiropractic adjustments were designed to help her preexisting low back conditions, rather than the arm, shoulder and neck complaints from her compensable injury. The chiropractic adjustments have been the major cause of her low back condition."

It is the task of this Board to determine causation based on facts demonstrated in the record. On occasion, it is appropriate to infer the existence of facts that have not been proven from facts that are present in the record. This indirect proof of essential facts is acceptable, if and only if, the inference is the only possible inference, or at least the most likely of several inferences that may be drawn from the same proven facts. See Topco Associates v. First National Bank of Portland, 202 Or 32 (1954).

In this case there is no direct evidence that claimant suffered from a preexisting condition. The proven facts demonstrate that claimant experienced a relatively minor injury to her low back in September 1986 that rapidly resolved, and that a similar injury occurred in October of 1987 and likewise rapidly resolved. By the time of the injury to claimant's neck shoulder and arm on November 30, 1987 she was experiencing no symptoms related to her low back, and continued asymptomatic, by the Referee's specific findings, through April of 1988. The only explanation for a recurrence of symptoms offered by any party and demonstrated by the evidence is the chiropractic adjustment claimant received on June 7, 1988 from Dr. Simonson.

Neither the Referee, nor a majority of the Board, has offered any indication of what they believe the preexisting condition, from which claimant supposedly suffered, actually was. However, it is apparent from the findings of the Referee that it was not the low back condition of 1986 or the low back strain of October 1987. By specific findings both of those conditions had fully resolved. In any event, the mere fact that an injury has occurred at some time in the past is not sufficient to establish that claimant suffers from a preexisting condition. The record must establish some basis for the conclusion that a condition deriving from prior injury continues to exist.

In this case, that evidence must go even further. If the low back condition for which claimant sought treatment after April 1988, derived from the injury of October 1987, claimant would still have established the compensability of her herniated disk at L5-S1 and chronic lumbar strain, because the injury of October 1987 was itself work related.

The existence of a preexisting condition in the present claim arises from speculation only. Drs. LaFrance and Worthington, both of whom treated claimant prior to June of 1988 agreed that claimant did not suffer low back symptoms at the time of their treatment. (Exs. 33 and 34, respectively.) The speculation regarding a preexisting low back condition arises from the April 17, 1991 retrospective report of Dr. Brittain, and the first medical report of Dr. Simonson.

The first medical report filed by Dr. Simonson, referencing claimant's low back complaints, did not occur until July 5, 1988 one month after he began treatment, and well after claimant alleges he caused the onset of low back symptoms. Consequently, it would be inappropriate to conclude that the first medical report establishes that claimant experienced low back symptoms at the time she first sought treatment from Dr. Simonson. Those symptoms could have arisen with the first treatment on June 7, 1988 just as claimant alleges, and the report of Dr. Simonson on July 5, 1988 would still be an accurate representation of her complaints. (Ex. 8.)

The sole remaining evidence that might be used to establish the existence of low back symptoms prior to the June 7, 1988 treatment by Dr. Simonson is the retrospective report of Dr. Brittain. (Ex. 32A.) The portion of that report that is of significance in this proceeding is as follows:

> "Her lower back complaints were not significant enough to take a thorough history and examination, however, there were a couple of times I did adjust her lower back for alleviation which proved quite successful. After her move to California she stated that she had had problems with her lower back after seeing a doctor down there and had complaints on November 17, 1989 of entire spine pain and she asked me to adjust her to alleviate those. I did based on my minimal evaluation and treatment"

The proper interpretation to be given to this report is the core of the present dispute. As noted by Dr. Woolpert, the report is not clear on the date low back treatment first began. The report could be referencing lower back pain both before and after claimant's period of treatment in California. However, the reference to a minimal examination both in the first and last sentence, and the clarification in the last sentence that the examination occurred after November 17, 1989 would indicate that lower back pain arose in California from the treatment provided by Dr. Simonson.

If the claimant is presumed to be credible, the second interpretation of this report is the only possible interpretation. Even if we assume that there are two possible interpretations, this report, alone, does not indicate that claimant is untrustworthy, since, like the first medical report of Dr. Simonson, it is not facially inconsistent with the history offered by claimant.

On this record, the evidence presented by the insurer to support its allegation that claimant was receiving treatment for a preexisting low back condition is so vague and confusing that it fails even to successfully challenge the history offered by claimant. Certainly, it does not reach that level of particularity and substance necessary to justify a finding that claimant is less than fully credible in her description of the onset of her condition. See Peterson v. E.F. Burril Lumber, 57 Or App 476 (1982).

Because the evidence regarding any alleged preexisting condition is speculative at best, the conclusion that claimant suffered a preexisting condition is inappropriate. Speculation, even when indulged in by medical experts in the process of rendering an opinion, unless supported by sound medical reasoning, is not substantial evidence. Anderson v. Sturm, 209 Or 190 (1956).

Even if claimant did suffer from an ongoing low back condition, the evidence in the present record does not establish that claimant was actually receiving treatment for that condition on June 7, 1988. Her history at that time references only the electric shock injury with nerve damage and cervical sprain/strain. (Ex. 8). Ostensibly, it is this injury for which Dr. Simonson rendered treatment. To conclude otherwise is pure speculation unsupported by any evidence in the record. Therefore, I must dissent.

In the Matter of the Compensation of
**MICHAEL L. DODSON, Claimant**
WCB Case No. 91-10369
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The SAIF Corporation requests review of that portion of Referee Brazeau's order which awarded a penalty for its allegedly unreasonable delay in accepting claimant's aggravation claim for a psychological condition. Claimant cross-requests, arguing that the Referee erred in declining to assess an attorney fee for prevailing against SAIF's de facto denial. On review, the issues are penalties and attorney fees. We modify.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the third paragraph on page 2 of the order, with the following supplementation.

Three days after his claim was closed, claimant sought treatment for depression from Douglas County Mental Health. On May 15, 1991, claimant filed a request for reconsideration of the March 21, 1991 Determination Order. That document claimed that claimant needed treatment and had disability related to psychological problems that stemmed from the compensable injury. SAIF received this document on May 20, 1991.

## CONCLUSIONS OF LAW AND OPINION

### Unreasonable Delay in Denying the Claim

The Referee found that claimant's July 29, 1991 request for hearing constituted a claim and, therefore, concluded that SAIF's November 1, 1991 acceptance was unreasonably late and assessed a penalty. We agree that SAIF's acceptance of claimant's aggravation claim was unreasonably late. However, we conclude that SAIF had actual notice of claimant's aggravation claim on May 20, 1991.

Notice or knowledge of an aggravation claim may be acquired directly from claimant or through another source. ORS 656.273(2). Once notified of the claim, the insurer must accept or deny the claim within 90 days, or risk imposition of penalties. See ORS 656.262(6); ORS 656.273(6); Bryan L. Dunn, 43 Van Natta 1673 (1991).

Here, following a March 21, 1991 Determination Order closing claimant's right wrist condition, claimant sought treatment for a psychiatric disorder from Douglas County Mental Health. (Ex. 27a-1). On May 15, 1991, claimant filed a request for reconsideration of the Determination Order with the Department. In that request claimant stated:

> "1. Michael Dodson has reflex sympathetic dystrophy and psychological problems as sequelae to this injury that are respectively untreated and poorly diagnosed. He should still be receiving temporary total disability/temporary partial disability.
>
> "2. He is not yet medically stationary for reflex sympathetic dystrophy and psychiatric.
>
> "3. As in 1 and 2.
>
> "5. If determined to be medically stationary, then request arbiter to establish diagnosis for psychiatric per DSM III-Rev and rate impairment, and request that the director establish a special rule for rating of reflex sympathetic dystrophy and request that findings for reflex sympathetic distrophy be established for impairment rating.
>
> "6A. Psychological sequelae of industrial injury require factors.

"7. At present, Michael Dodson is permanently and totally disabled as a result of this industrial injury." (Ex. 32).

SAIF received this on May 20, 1991. We conclude claimant's May 15, 1991 request for reconsideration constituted a claim. Therefore, SAIF was required to accept or deny claimant's psychological claim within 90 days of the claim on May 20, 1991, or by August 18, 1991. SAIF failed to do so.

However, meanwhile, claimant had filed a request for hearing on July 29, 1991 raising as an issue de facto denial and "[c]ompensability of psychiatric condition as sequela of injury." On August 22, 1991, SAIF responded to the request by asserting that the denial should be affirmed. It was sent to the Hearings Division and copied to claimant's attorney. SAIF now asserts that the August 22, 1991 document should be deemed its denial, making its claim processing obligation only four days late. That would have been true based on past Board policy. Martha A. Baustain, 35 Van Natta 1287 (1983). However, this was disavowed in Roger Prusak, 40 Van Natta 2037 (1988). Usually, there must be a formal denial to stop the time running. Here, SAIF neither formally accepted nor denied the claim until November 1, 1991, when it issued its formal acceptance of claimant's aggravation claim for the psychological condition. However, the claim was orally denied at the hearing on October 31, 1991. That oral denial at hearing stopped the time from continuing to run. John Davison, 44 Van Natta 518 (1992).

Because SAIF did not accept or deny the claim within 90 days, a penalty may be assessed under ORS 656.262(10), if there were amounts then due between the date when the acceptance or denial should have issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). In this case, the record does not support a finding that there were amounts due at the time of the unreasonable delay, and therefore, 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 that 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), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

In the present case, SAIF did not respond within 90 days as required by ORS 656.262(6). By failing to timely respond, it delayed the process and the ultimate resolution of the compensability issue. Therefore, 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 SAIF's rescission and acceptance of the claim. Therefore, SAIF unreasonably resisted payment of compensation and an attorney fee under ORS 656.382(1) is assessed on this basis. See Tami L. Farrell, 43 Van Natta 2727 (1992); Richard J. Stevenson, 43 Van Natta 1883 (1991); Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 41 Van Natta 2259 (1989).

De Facto Denial

The Referee allowed claimant's counsel an out-of-compensation attorney fee equal to 25 percent of the additional compensation to which claimant was entitled to as a result of the acceptance of claimant's aggravation claim. However, inasmuch as we have herein concluded that SAIF failed to accept or deny the claim within the 90-day statutory period, we also find that claimant's aggravation claim was denied on a de facto basis prior to the October 31, 1991 hearing. See Barr v. EBI Companies, 88 Or App 132 (1987); Doris I. Hornbeck, 43 Van Natta 2397 (1991). Therefore, we further find that SAIF's acceptance following the hearing constituted a rescission of its de facto denial. Moreover, in light of the fact that SAIF accepted claimant's aggravation claim one day after the hearing, we conclude that claimant's counsel was instrumental in obtaining SAIF's rescission and compensation for claimant's aggravation claim. Therefore, claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1), instead of a fee out of claimant's compensation fee.

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 fee for claimant's counsel's services concerning SAIF's unreasonable resistance to the payment of compensation is $500 and rescission of SAIF's de facto denial is $2,000, for a total fee of

$2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues, as represented by the record, the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated January 8, 1992 is modified in part and affirmed in part. That portion of the Referee's order which assessed a penalty is modified to award an assessed attorney fee of $500 for claimant's counsel's services concerning the SAIF Corporation's unreasonable resistance to the payment of compensation. In lieu of the Referee's award of an attorney fee out of claimant's compensation, claimant is awarded an assessed fee of $2,000 for counsel's services concerning SAIF's rescission of its de facto denial. The total assessed attorney fee awarded is $2,500, to be paid by SAIF. The remainder of the order is affirmed.

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February 10, 1993 Cite as 45 Van Natta 200 (1993)

In the Matter of the Compensation of
**BILL M. LONG, JR., Claimant**
WCB Case No. 91-14413
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The insurer requests review of that portion of Referee Quillinan's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of those portions of the Referee's order that: (1) affirmed the Order on Reconsideration that affirmed the Notice of Closure award of 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the right arm; and (2) declined to assess a penalty and/or attorney fee for the insurer's allegedly unreasonable delay in completing a vocational eligibility evaluation. On review, the issues are extent and rate of scheduled permanent disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Disability

The Referee declined to rate the extent of claimant's permanent disability because claimant was not medically stationary either at the time of hearing or at the time the Referee issued her order. Subsequent to the date of issuance of the Order on Reconsideration and before the date of the hearing, claimant's attending physician requested authorization for surgery for claimant's compensable condition.

The Referee apparently based her decision on prior case law which held that a referee should not rate permanent disability if the claimant is not medically stationary at the time of hearing or the claim is in open status. See, e.g., Kociemba v. SAIF, 63 Or App 557 (1987). We have applied that rule where the claimant was medically stationary at the time of claim closure, but, at the time of hearing, the claim was in open status or the claimant was not medically stationary because of a subsequent aggravation. E.g., Glean A. Finley, 43 Van Natta 1442 (1991); Raymond E. Pardee, 41 Van Natta 548 (1989); Theresa Skoyen, 39 Van Natta 462 (1987).

In Finley, the claimant had requested a hearing on a determination order which issued before his claim was reopened for a subsequent aggravation. The claim remained in open status at the time of hearing. We stated that, because permanent disability is evaluated at the time of hearing, it would be extremely confusing, if not impossible, to rate claimant's disability, disregarding any permanent contribution which resulted from a subsequent aggravation. Id. at 1444. Thus, based on notions of practicality, we declined to rate claimant's permanent disability.

In 1990, however, the legislature amended ORS 656.283(7) to provide that the "[e]valuation of the worker's disability by the referee shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268." See also ORS 656.268(5); Heather I. Smith, 44 Van Natta 2207 (1992); Vickie M. Libel, 44 Van Natta 294, recon 44 Van Natta 413 (1992). Amended ORS 656.283(7) applies here because claimant became medically stationary after July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, § 54(3). Accordingly, a claimant's permanent disability is no longer rated at the time of hearing. Thus, the fact that claimant was not medically stationary at the time of hearing did not preclude the Referee from rating his permanent disability. We conclude, therefore, that the Referee should have rated claimant's permanent disability.

Nonetheless, because we find that the record is sufficiently developed for our evaluation of claimant's permanent disability, we proceed to that evaluation. Because claimant became medically stationary after July 1, 1990, and the Notice of Closure issued on August 20, 1991, we apply the standards for rating permanent disability which took effect April 1, 1991. See OAR 436-35-003(2). Those standards are in WCD Administrative Order 2-1991.

Claimant contends that the Notice of Closure award of 5 percent scheduled permanent disability for the right arm is inadequate. Specifically, he contends that he is entitled to an additional award for the loss of grip strength in his right hand. We disagree.

Dr. Mandiberg, the attending physician, wrote in his closing evaluation report on August 1, 1991, that claimant had grip strength of 120 on the right, and 135 on the left. (Ex. 32-1). However, there is no medical evidence that the lesser grip strength on the right is attributable to the compensable epicondylitis condition. Dr. Mandiberg neither described nor rated claimant's grip strength as a permanent impairment. Absent medical evidence relating the right grip strength finding to the compensable condition, claimant is not entitled to an award based on lost grip strength.

Claimant next argues that he is entitled to a 5 percent award for a chronic condition limiting repetitive use of the right hand. We disagree. Dr. Mandiberg wrote that claimant is entitled to two separate 5 percent awards for chronic conditions limiting repetitive use of the right elbow and hand. (Ex. 32-2). However, former OAR 436-35-010(6)(b) provides:

> "Where scheduled chronic condition impairments exist for more than one body part in the same extremity, the worker shall receive only one 5% chronic condition impairment for the body part which results in the larger dollar amount of compensation to the worker. In no event is a worker entitled to more than one 5% scheduled chronic condition impairment in each injured extremity, regardless of how many body parts within that extremity are injured or have chronic conditions."

Under this rule, claimant is entitled to only one 5 percent chronic condition award for the right upper extremity. Inasmuch as the chronic condition award for the right elbow would result in the larger dollar amount of compensation to the worker, we conclude that claimant is entitled to no more than the 5 percent chronic condition award for the right elbow. Accordingly, we conclude that claimant is entitled to no more than the 5 percent scheduled permanent disability granted by the Notice of Closure/Order on Reconsideration for the loss of use or function of the right arm.

Rate of Scheduled Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Penalties and Attorney Fees

Claimant seeks a penalty or attorney fee for the insurer's allegedly unreasonable delay in completing an evaluation of claimant's eligibility for vocational assistance. The Referee found there was a delay in the completion of the evaluation, but concluded that there was no unreasonable delay in paying compensation. We disagree, and assess an attorney fee.

When a worker is found likely eligible for vocational assistance, or is found medically stationary and has not returned to regular or other suitable work for the employer, the insurer must contact the worker to determine eligibility for vocational assistance. OAR 436-120-035(4) and (5). Thereafter, the insurer has no more than 30 days in which to determine whether the worker is eligible for vocational assistance. OAR 436-120-035(6).

Dr. Mandiberg issued his closing report on August 1, 1991, declaring claimant medically stationary and recommending he be placed in a different job requiring lighter work with the right arm. (Ex. 32). The insurer received that report on August 15, 1991. By letter dated August 7, 1991, the insurer advised claimant that it was in the process of reviewing his eligibility for vocational assistance. The letter also requested written verification of any wages and unemployment benefits. (Ex. 33). Claimant provided the requested information about a week later. (Ex. 34).

On August 16, 1991, the insurer referred claimant's vocational file to Hetfeld Carter Associates (HCA) for a vocational eligibility evaluation. (Ex. 35). By letter dated September 3, 1991, Ms. Robertson, a vocational consultant with HCA, indicated that the employer had expressed interest in making modifications to claimant's job. (Ex. 38). That same day, claimant's attorney's legal assistant wrote the Rehabilitation Review Section (RRS) of the Workers' Compensation Division, requesting the assessment of civil penalties against the insurer for its delay in completing the vocational eligibility evaluation. (Ex. 39).

After several unsuccessful attempts to schedule a meeting with claimant, Ms. Robertson met with claimant on September 9, 1991, and completed two job analyses for review by Dr. Mandiberg. (Ex. 43). On September 20, 1991, RRS issued an order which dismissed claimant's request for civil penalties on the grounds that the insurer was proceeding with the eligibility evaluation and that any delay in completing the evaluation has been minimal and with reasonable cause. According to the order, the insurer had indicated that if the attempt to return claimant to work for the employer is unsuccessful, the eligibility evaluation will be completed by October 3, 1991. (Ex. 45).

On September 26, 1991, Dr. Mandiberg completed a physical capacities evaluation, disapproved the job analyses, and sent those materials to Ms. Robertson. (Exs. 46, 47, 48). The next day, Ms. Robertson forwarded those materials to the employer and requested a determination as to whether there was suitable work available for claimant. (Ex. 49). On September 30, 1991, Ms. Robertson contacted the employer for a verbal response. The employer declined to give a response until first contacting the insurer. (Ex. 50-6). By letter dated November 5, 1991, the insurer notified claimant that he is eligible for vocational assistance. (Ex. 54).

Claimant argues that the insurer failed to comply with a Director's order which directed it to complete the vocational eligibility evaluation by October 3, 1991. We find no such order by the Director. The Director's September 20, 1991 order did not direct the insurer to do anything; it merely dismissed claimant's request for civil penalties.

Claimant also argues that the insurer should have completed the eligibility evaluation by September 3, 1991. On that date, however, the vocational consultant to whom the insurer referred this matter did not have sufficient information for completing the eligibility evaluation.

One requirement for establishing eligibility for vocational assistance is a finding that, as a result of the limitations caused by the injury, the worker is unable to return to any suitable and available work with the employer. See OAR 436-120-040(4). To make this finding, the vocational consultant must have specific information concerning claimant's permanent limitations. Here, that information was not provided by Dr. Mandiberg until September 27, 1991. Thus, we do not find that the preceding delay was the result of any unreasonable conduct by the vocational consultant or the insurer.

However, we find that the insurer's subsequent delay in completing the eligibility evaluation was unreasonable. The employer received Dr. Mandiberg's physical capacities evaluation in late September 1991. At that time or shortly thereafter, the employer should have determined, in the exercise of reasonable diligence, whether there was any suitable work available within claimant's physical limitations. Yet, the insurer did not complete its eligibility evaluation until November 5, 1991, more than a month after the employer had received the physical capacities evaluation. The record does not support any reasonable explanation for that delay. Accordingly, we find that the insurer unreasonably delayed the payment of compensation.

We do not find that there were any amounts of compensation due at the time of the delay. Absent such amounts, there is no basis for a penalty. See ORS 656.262(10)(a). However, we assess a penalty-related attorney fee for the insurer's unreasonable resistance to the payment of compensation, i.e., the vocational services that were subsequently authorized on November 5, 1991. See ORS 656.382(1). 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 conduct is $400, to be paid by the insurer. 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 24, 1992 is reversed in part and affirmed in part. That portion of the order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of $305 per degree and awarded an "out of compensation" attorney fee from this increased compensation is reversed. Claimant is awarded an attorney fee of $400 concerning the insurer's unreasonable delay in completing the vocational eligibility evaluation, to be paid by the insurer. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**MELINDA A. SAHLFELD-SPARKS, Claimant**
WCB Case No. 91-12849
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee Bethlahmy's order which: (1) set aside its denial of claimant's right wrist tendinitis injury claim; and (2) set aside its denial of claimant's bee sting claim. On review, the issues are compensability.

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

Relying on the opinion of Dr. Peterson, claimant's attending physician, the Referee concluded that the compensability of claimant's right wrist tendonitis injury was established by medical evidence supported by objective findings. The Referee also determined that, because the bee sting occurred when claimant was returning from a doctor's appointment for her tendinitis condition, the bee sting claim was likewise compensable.

On review, the employer argues that: (1) there are no objective findings establishing claimant's wrist injury; (2) claimant failed to establish that her symptoms resulted from tendinitis, rather than carpal tunnel syndrome; and (3) claimant failed to provide a complete and accurate history to Dr. Peterson and, therefore, his opinion is unpersuasive. However, the employer also concedes in its brief that if claimant's right wrist tendinitis claim is compensable, the bee sting claim is also compensable.

As to the employer's first argument, we find that the record contains sufficient objective findings to support Dr. Peterson's opinion. "Objective findings" include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings. ORS 656.005(19). Moreover, as we stated in Suzanne Robertson, 43 Van Natta 1505 (1991), the "objective findings" requirement is satisfied if a physician's evaluation of a claimant's physical condition is based on her description of the pain she is experiencing. The report, however, cannot merely recite a claimant's complaints of pain, but rather must indicate that the claimant does, in fact, experience symptoms. Id.

Here, we find that while Dr. Peterson initially noted a "paucity of physical findings," he also found tenderness at the base of claimant's thumb. (Ex. 12). Additionally, he stated in his deposition testimony that claimant's responses to physical tests were not inconsistent and that when he pressed on her wrist, she experienced pain. (Ex. 20-17). Furthermore, he opined that claimant does, in fact, experience the pain symptoms she described. (Ex. 20-12). We find this sufficient to satisfy the "objective findings" requirement. See ORS 656.005(19); Suzanne Robertson, supra.

As to the employer's next argument, we conclude that the medical evidence is sufficient to establish that claimant's symptoms are the result of tendinitis, rather than carpal tunnel syndrome. Following claimant's June 12, 1991 injury, claimant sought treatment from an urgency care clinic. The initial urgency care chart notes indicated "strain ligament," and "right wrist pain," and "carpal tunnel syndrome." (Ex. 9-2). Claimant was referred to Dr. Harvey, who stated that claimant may have a fracture of the carpal bone. (Id.). Dr. Harvey referred claimant to Dr. Peterson. While Dr. Peterson noted that claimant had "some features suggestive of carpal tunnel syndrome," his chart notes indicate that, based on his examination, claimant's symptoms are the result of tendinitis. (Exs. 12, 17-2, 20-6). Moreover, Dr. Peterson testified that he discounted Dr. Nathan's diagnosis of carpal tunnel syndrome because "Dr. Nathan has a way of diagnosing carpal tunnel syndrome that does not seem to be reproducible by most other practitioners." (Ex. 20-8, 20-12, 20-16). We conclude that this evidence is sufficient to establish that claimant's symptoms are the result of tendinitis.

Finally, we do not find the employer's argument regarding the reliability of claimant's reported history to be persuasive. We agree with the employer that the description claimant initially gave to Dr. Peterson overstated the number of hours that she operated the "Weed-Eater," in comparison to her work logs. However, the record also indicates that claimant operated the "Weed-Eater" in excess of six hours a day on several occasions and suggests that the work logs may not have recorded all of the hours claimant operated that equipment. (Tr. 12-14, 27-31, 42; Ex. 19). Furthermore, even after Dr. Peterson was given a more accurate account of the number of hours that claimant operated the "Weed-Eater," he continued to opine that claimant's right wrist tendinitis was the result of a work injury. (Ex. 20-11).

Consequently, we conclude that the Referee correctly determined that claimant's right wrist tendinitis injury claim is compensable. Accordingly, inasmuch as the employer has conceded that the bee sting claim is also compensable if the right wrist tendinitis condition is compensable, we hold that claimant has established the compensability of both claims.

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 is $1,000, 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 April 2, 1992 is affirmed. For services rendered on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
**TONY E. ALFANO, Claimant**
Own Motion No. 87-0237M
RECONSIDERATION OF OWN MOTION ORDER OF DISMISSAL
Royce, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of our December 14, 1992 Own Motion Order of Dismissal in which we set aside the employer's Notice of Closure and remanded claimant's claim to the employer for further processing to closure pursuant to ORS 656.268.

On January 11, 1993, we abated our December 14, 1992 order to allow claimant an opportunity to respond. Claimant's response has been received. After review of the employer's motion, along with claimant's response, we adhere to our prior conclusions.

In our December 14, 1992 order, we based our decision, in part, on Carter v. SAIF, 52 Or App 1027 (1981), and Coombs v. SAIF, 39 Or App 293 (1979). The employer argues that these cases are distinguishable. Specifically, it argues that these cases, in effect, preserve claimant's right to appeal the final determination of his permanent disability. However, it argues that there is no need to preserve this right in the present case because claimant actually appealed his final determination of permanent disability, although he later withdrew that appeal. Thus, it argues, the Notice of Closure properly closed claimant's claim pursuant to ORS 656.278.

However, we find that the distinction the employer makes is of no consequence. We emphasize that our holding was also based on ORS 656.278(2). The language of ORS 656.278(2) as applied by Carter v. SAIF, supra, and Coombs v. SAIF, supra, compels the result reached in our December 14, 1992 order.

ORS 656.278(2) was not changed by the 1990 amendments to the Workers Compensation Law. Therefore, this statute retains the same language it had when it was applied by the Court of Appeals in Carter v. SAIF, supra, and Coombs v. SAIF, supra. ORS 656.278(2) provides that "[a]n order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS 656.273 is not an order or award, as the case may be, made by the board on its own motion." In construing this language, the court concluded that a claim that is reopened while the worker still has appeal rights shall be closed with rights of appeal whenever it is closed. Coombs v. SAIF, supra, 39 Or App at 300.

Thus, the determinative point is whether the claim was opened while claimant had appeal rights, not whether claimant independently pursued those appeal rights by appealing the previous closure. Here, claimant's claim was reopened under the Board's own motion authority on June 30, 1987, within the period for appealing from the Determination Order. Regardless of whether claimant independently appealed that Determination Order, the fact remains that his claim was reopened during the appeal period. Therefore, pursuant to ORS 656.278(2), the claim may not be closed by the Board in its own motion capacity. Rather, closure must be made pursuant to ORS 656.268 with all rights of appeal. Carter v. SAIF, supra; Coombs v. SAIF, supra; Rosemary J. Harrell, 42 Van Natta 639 (1990).

Claimant requests an assessed attorney fee pursuant to ORS 656.382(2) for prevailing over the employer's request for reconsideration of our Own Motion Order of Dismissal. Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). We recently held that ORS 656.382(2) is not applicable in the own motion setting. Donald E. Woodman, on recon, 45 Van Natta 4 (1993). Therefore, we have no statutory authority to grant the assessed attorney fees requested by claimant.

Accordingly, our December 14, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 14, 1992 order effective this date. 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
**DANIEL J. COSTANZO, Claimant**
WCB Case No. 91-14579
ORDER ON REVIEW
Charles D. Beshears, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of that portion of Referee Hoguet's order that: (1) set aside an alleged de facto denial of medical services; and (2) contingently awarded an assessed attorney fee. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of claimant's aggravation claim for a back injury. On review, the issues are aggravation, medical services, 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 OPINION

### Aggravation

In order to prove a compensable aggravation, claimant must prove a worsened condition "resulting from the original injury." ORS 656.273(1). The Referee found that, based on a previous Referee's order, the insurer had not accepted the condition that is the basis for claimant's aggravation claim. Therefore, the Referee found that claimant's condition did not result from the original injury and, thus, the aggravation claim failed.

In 1989, before Referee Menashe, claimant litigated the insurer's partial denial of several conditions stemming from a March 1988 industrial injury. Claimant asserts that Referee Menashe's order should be interpreted as using the terms "degenerative disc disease" interchangeably with "disc protrusion or disc defect" and that the Referee merely found that claimant's condition at L5-S1 was compensable but that his condition at L4-5 was not compensable, whether such conditions constituted degenerative disc disease or disc protrusion. We disagree.

Throughout the order, Referee Menashe clearly viewed claimant's overall back condition as consisting of a degenerative disc disease and disc protrusions at L5-S1 and L4-5, and treated the degenerative disc disease as being separate and distinct from the disc protrusions. For instance, Referee Menashe stated that the issue being litigated was whether or not the conditions listed in the insurer's partial denial resulted from the industrial injury. (Id. at 3). That denial listed each condition separately. (Id. at 1). Furthermore, in discussing compensability, Referee Menashe referred to each condition separately, stating that, although claimant proved that "the L5-S1 disc protrusion resulted from the injury of March 7, 1988," claimant had failed to prove that "the injury caused or worsened the degenerative disc disease or the L4-5 defect." (Id. at 4) (emphasis added). Finally, in the order portion, Referee Menashe set aside the denial of "disc protrusion at L5-S1," but upheld "the denial at L4-5 and degenerative joint [sic] disease." (Id. at 6) (emphasis added). Therefore, we find that the only condition ordered to be accepted by the insurer was a disc protrusion at L5-S1.

In explaining the cause of claimant's current condition, Dr. Hazel, orthopedic surgeon and claimant's treating physician, stated that "it appears that the nature of the injury accepted on [sic] [claimant] in 1988 was degenerative lumbosacral intervertebral disc disease" and that this was the "same disc that is currently causing sciatica[.]" (Ex. 22). Dr. Hazel further reported that it was not "medically probable that [claimant's] L5-S1 degenerative disc disease worsened" but that he had experienced a "temporary exacerbation of symptoms referable to the degenerative disc disease." (Id).

We conclude that, based on Dr. Hazel's report, claimant's current symptoms are caused by a degenerative disc disease at L5-S1. However, because, as found above, the insurer was ordered to accept only a disc protrusion at L5-S1 and claimant's degenerative disc disease, at whatever level, was found to be not compensable, we further conclude that the condition for which claimant currently seeks treatment did not result from the injury. Therefore, claimant's aggravation claim fails.

Medical Services

The insurer next challenges the Referee's conclusion that Dr. Hazel's medical bills are compensable as diagnostic services.

Under ORS 656.245(1)(a), "for every compensable injury," a worker is entitled to "medical services for conditions resulting from the injury[.]" The statute extends to payment of diagnostic services relating to noncompensable conditions if such procedures are performed to determine whether or not a causal relationship exists between the industrial injury and the noncompensable condition. See Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982). We have original jurisdiction to address a dispute concerning whether diagnostic services are related to a compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992).

Here, as discussed above, the medical services rendered by Dr. Hazel related to claimant's degenerative disc disease at L5-S1, a noncompensable condition. Furthermore, we find no indication in the record that Dr. Hazel's medical services were performed to determine whether or not a causal relationship existed between this condition and the industrial injury. On the contrary, Dr. Hazel erroneously believed that this condition had been previously accepted by the insurer. (Ex. 22). He, therefore, had no reason for investigating any causal relationship. Accordingly, we conclude that Dr. Hazel's medical services are not compensable as diagnostic services. Consequently, claimant's attorney is not entitled to an assessed fee on this basis.

ORDER

The Referee's order dated March 10, 1992 is reversed in part and affirmed in part. That portion of the order finding that Dr. Hazel's bills were compensable as diagnostic services is reversed. The Referee's contingent attorney fee award is reversed. The remainder of the order is affirmed.

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February 11, 1993 Cite as 45 Van Natta 207 (1993)

In the Matter of the Compensation of
**STEVEN S. EWEN, Claimant**
WCB Case No. 91-07052
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of those portions of Referee Bethlahmy's order which: (1) declined to admit Exhibit 43 into evidence; (2) declined to award additional temporary disability benefits; and (3) declined to assess penalties and attorney fees for the self-insured employer's allegedly unreasonable claim processing. On review, the issues are evidence, temporary disability, and penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

In July 1987, claimant compensably injured his left foot. On March 12, 1988, claimant's foot condition was found to be medically stationary. Subsequently, claimant returned to modified work as a fork lift operator with his at-injury employer.

On April 16, 1990, claimant was informed that he was to be transferred to another position. Within 24 hours, he was considering suicide. Thereafter, claimant contacted Dr. Kohen, a psychologist, who claimant had seen the previous month for off-work stress.

On Dr Kohen's recommendation, claimant was admitted to Province Medical Center for depression. Claimant was hospitalized from April 17, 1990 through April 23, 1990. In May 1990, claimant returned to work for two days. However, Dr. Kohen released claimant from work due to "stress related difficulties" from May 7, 1990 through May 12, 1990.

On May 15, 1990, a Determination Order closed claimant's foot injury claim. In addition to temporary disability, claimant was awarded 25 percent scheduled permanent disability benefits for loss of his left great toe and 25 percent scheduled permanent disability benefits for loss of his left second toe.

In June 1990, claimant was terminated from his job "for failure to call in." (Ex. 21). The employer denied claimant's depression condition on July 11, 1990. On July 26, 1990, through union intervention, it was determined that claimant could be reinstated at his job with a "loss of seniority." (Id). Claimant voluntarily did not return to his job for reasons unrelated to his compensable conditions. He began receiving unemployment compensation.

On October 5, 1990, Dr. Kohen released claimant from work at his former job "due to his present psychological and physical disabilities which are secondary to his occupational injury." (Ex. 22).

Between January 1991 and May 1991, claimant worked for a number of other employers. On March 23, 1991, claimant's employer advised him that there were no current positions available within his physical limitations as set forth by Dr. Erde. These limitations pertained to claimant's compensable foot condition. (Ex. 27A).

On May 3, 1991, Referee Menashe found that claimant's compensable foot injury was the major contributing cause of his major depression on April 17, 1990. Referee Menashe's order set aside the employer's denial and directed it to accept claimant's psychological condition effective April 17, 1990 and provide benefits required by law. The Referee made no findings on temporary disability, reasoning that "although claimant was hospitalized on April 17, 1990, the record did not show how long he was off work because of the psychological condition." (Ex. 28). The employer requested Board review of the Referee's order. On February 20, 1992, the Board affirmed Referee Menashe's May 3, 1991 order.

On May 16, 1991, the employer paid claimant temporary total disability benefits for his April 1990 hospitalization. (Ex. 29).

On May 31, 1991, Dr. Kohen recommended vocational rehabilitation assistance. (Ex. 32). Dr. Kohen reported that claimant's "self-esteem is intricately woven within his occupational functioning and the best prognosis for him psychologically depends on returning to work in a capacity that does not diminish his sense of self, e.g. at a minimum wage type job." (Ex. 32). Since claimant could not return to his at-injury job, Dr. Kohen authorized time loss "until such time as vocational retraining is completed and employment is found that is comparable in wage and responsibility and is within the physical limitations noted by Dr. Erde." (Ex. 34A).

Subsequently, the employer issued a time loss payment on July 10, 1991 and on July 24, 1991, in regard to claimant's psychological condition. The employer also scheduled an independent medical examination with Dr. Klein, psychiatrist.

On July 15, 1991, Dr. Klein opined that claimant was not in need of any further psychiatric treatment. (Ex. 37-4). Dr. Klein did not believe that claimant was emotionally disabled from employment. (Id). Dr. Klein also concluded that the cause of claimant's depressive symptoms were "some relating to his job, some relating to his family life, and others, probably, to the playing out of his removal from general substance abuse." (Ex. 37-4,5).

On July 24, 1991, Dr. Turco, psychiatrist, evaluated claimant. (Ex. 39). Dr. Turco reported that claimant did not have an emotional disorder that would interfere with his work or his motivation to return to work. (Ex. 39-6). Dr. Turco further opined that the cause of claimant's depressive experiences were environmental problems, e.g., "the cessation of time loss payments by the insurer, rearrangements by the employer," rather than the injury itself. (Id).

After receiving Dr. Klein's medical report, the employer determined that claimant's current psychological condition had not become disabling. Consequently, on July 25, 1991, the employer issued a denial of further temporary disability benefits. (Ex. 38).

On July 30, 1991, claimant was admitted to Province Medical Center due to suicidal depression. Dr. Erde reported that "this hospitalization is an aggravation of his accepted depression. His depression has been accepted by Workers' Compensation as being secondary to his work-related injury." (Ex. 39A).

On August 8, 1991, Dr. Kohen reported that claimant's psychological condition was not medically stationary and that claimant's treatment was curative. On August 19, 1992, the employer issued an aggravation denial of claimant's psychological condition. Claimant requested a hearing concerning the employer's denials, as well as its failure to process the depression condition in accordance with the earlier Referee's order.

## CONCLUSIONS OF LAW AND OPINION

### Evidentiary Matter

Claimant objects to the Referee's decision to not admit Exhibit 43. We conclude that the decision was within the discretion of the Referee.

At the close of the first session of the hearing, Exhibits 1 through 42 had been admitted into the record. Claimant was in receipt of Exhibit 43 on or about the day of the first hearing, but did not offer it into evidence on that date. Neither did claimant request, nor was permission granted by the Referee, to keep the record open for the receipt of additional evidence following the first session of the hearing. It was not until the day of the second session, some 30 days after the first, that claimant offered Exhibit 43.

Pursuant to OAR 438-07-018(4), the Referee has discretion to admit or exclude evidence not submitted in accordance with the Board's rules. Under the aforementioned circumstances, we conclude that the Referee did not abuse her discretion in excluding Exhibit 43. Accordingly, we affirm her evidentiary ruling.

### Temporary Disability

In his request for hearing, claimant sought enforcement of Referee Menashe's May 3, 1991 order. (Ex. 28). Specifically, claimant sought temporary disability compensation due to his psychological condition, which Referee Menashe found to be compensable. In finding the condition compensable, Referee Menashe directed the employer to provide compensation as required by law. However, the Referee made no findings on temporary disability. The employer paid claimant temporary disability benefits from April 17, 1990 through April 23, 1990, and on July 10 and 24, 1991, and contends that no more is due. We disagree.

When the employer requested Board review of Referee Menashe's order, challenging compensability of the psychological condition, the compensation appealed from was stayed, except "[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." ORS 656.313(1)(a)(A). Raymond J. Seebach, 43 Van Natta 2687 (1991). Thus, claimant is entitled to receive temporary disability benefits that are payable from the date of Referee Menashe's May 3, 1991 order for his compensable psychological condition pending the employer's appeal of that decision. The employer would not be required to pay temporary disability accruing prior to the date of the appealed Referee's order. ORS 656.313(1)(a)(A).[1]

Therefore, the question for our consideration is the amount of post-May 3, 1991 temporary disability due claimant as a result of Referee Menashe's order. Specifically, the question is whether any event provided in ORS 656.268 for unilateral termination of temporary disability benefits was met. ORS 656.268(3) provides that temporary total disability 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).

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[1] Nevertheless, because the Referee's decision has subsequently been affirmed, claimant is entitled to receive those accrued but stayed temporary disability benefits as well. However, because those subsequent circumstances did not exist at the time of the hearing, claimant was not entitled to the payment of those benefits at that time.

Here, claimant was hospitalized from April 17, 1990 through April 23, 1990 for his compensable psychological condition. Claimant returned to work on May 1, 1990. Thus, the employer's initial procedural obligation to pay temporary disability ended as of May 1, 1990. (As previously discussed, such compensation could be stayed by virtue of the employer's appeal.)

However, on May 7, 1990, Dr. Kohen released claimant from work from May 7, 1990 through May 12, 1990 due to "stress related difficulties." (Ex. 6). Inasmuch as the psychological claim remained in open status, this release reinstated the employer's obligation to pay temporary total disability. ORS 656.210. Subsequently, claimant returned to work on May 13, 1990. Thus, the employer's procedural obligation to pay temporary disability ended again as of May 13, 1990. (As previously noted, such compensation could be stayed.)

On October 5, 1990, Dr. Kohen released claimant from work "due to his present psychological . . . disabilities which are secondary to his occupational injury." (Ex. 22). This release reinstated the employer's obligation to pay temporary total disability. Thereafter, claimant's claim continued in open status and none of the circumstances justifying the termination of temporary disability compensation under ORS 656.268(3) occurred.

Therefore, based on Dr. Kohen's releases from work, the employer was procedurally obligated to pay temporary disability from April 17, 1990 to May 1, 1990, from May 7, 1990 through May 12, 1990, and from October 5, 1990 through the proper closure of claimant's claim. Nevertheless, because the employer had appealed Referee Menashe's May 3, 1991 order finding claimant's psychological condition compensable, "pre-May 3, 1991" temporary disability could be stayed. Thus, claimant was entitled to temporary total disability from May 3, 1991 until this compensation could be lawfully terminated.

Accordingly, in lieu of the Referee's order, we direct the employer to process claimant's psychological claim to closure as required by ORS 656.268. In addition, we order the employer to pay all compensation due under the psychological claim, less any wages earned and less any amounts already paid for the same period under claimant's foot claim. See Fischer v. SAIF, 76 Or App 656 (1985); Ernest J. Myers, 44 Van Natta 1052, 1055 (1992).

The Referee found that the employer unreasonably refused to pay compensation. We disagree in part.

Given our findings regarding the employer's procedural obligation to pay temporary disability compensation, we find that the employer was not unreasonable in terminating temporary disability benefits during the period in which the compensation appealed from could be stayed pursuant to ORS 656.313. However, we have also concluded that the employer had no authority to unilaterally terminate claimant's "post-May 3, 1991" temporary disability benefits. Further, we find the employer's conduct unreasonable for failing to close claimant's claim when he returned to work and then failing to reinstate temporary disability benefits during claimant's subsequent releases from work as authorized by Dr. Kohen. Under the circumstances, we find that the employer's conduct was unreasonable and we assess a 25 percent penalty based on temporary disability due between May 3, 1991 through the August 26, 1991 hearing. ORS 656.262(10)(a). One-half of the penalty amount shall be awarded to claimant's counsel in lieu of an attorney fee made payable by this order.

Lastly, we address the employer's July 25, 1991 aggravation denial in this matter. Inasmuch as claimant's claim has remained in open status and there has been "no last arrangement of compensation" from which to measure a worsening, the employer's purported aggravation denial has no effect.

## ORDER

The Referee's order dated November 4, 1991, is modified in part and reversed in part. Claimant is awarded additional temporary disability benefits, less wages earned and previously paid temporary disability, beginning May 3, 1991, and continuing until such benefits can be lawfully terminated according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant is awarded an additional 25 percent of the compensation awarded by this order (from May 3, 1991 through the date of hearing) as a penalty for the employer's unreasonable conduct. One-half of this penalty shall be payable to claimant's attorney.

In the Matter of the Compensation of
**TOM FREDRICKSON, Claimant**
WCB Case No. 91-07155
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of that portion of Referee Brown's order that awarded an assessed attorney fee. Claimant cross-requests review of that portion of the order that declined to award a penalty and attorney fees for an allegedly unreasonable denial of temporary total disability benefits. Claimant also requests that the Board "correct the record" to include additional evidence. On review, the issues are evidence and penalties and attorney fees. We grant claimant's motion, affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

At the beginning of hearing, the insurer's attorney agreed to submit a master exhibit list post-hearing. (Tr. 1). Following issuance of the Referee's order, claimant's attorney moved to "correct the record" by admitting a July 25, 1989 Physical Capacity Evaluation that had been inadvertently excluded from the master exhibit list by the insurer's counsel. The insurer's attorney did not object to the motion. On March 27, 1992, the Referee issued an "Order Correcting Record" that admitted the document as Exhibit 21A. However, prior to the issuance of the order, on March 26, 1992, the insurer's attorney timely requested review of the Referee's order, thereby depriving the Referee of jurisdiction over the matter before he granted claimant's motion. See Ramey S. Johnson, 40 Van Natta 370 (1988). The Referee's order therefore had no effect.

On review, claimant seeks to include the document in the record. Inasmuch as it appears that the parties and the Referee intended to admit the document; it was not admitted at hearing due to an oversight by the insurer's attorney; the Referee was prevented from correcting the record by the insurer's filing of the request for review; and the insurer does not object to claimant's motion on review, we consider the exhibit on review. See Aletha R. Samperi, 44 Van Natta 1173 (1992); Pete Topolic, 44 Van Natta 1604 (1992).

### Penalty

We affirm and adopt the Referee's "Opinion" with regard to the penalty issue.

### Assessed Attorney Fee

The Referee, after concluding that claimant was entitled to temporary disability, awarded an assessed fee of $2,800. The insurer asserts that, because the denial concerned only the amount of compensation rather than whether or not claimant's condition was caused by an industrial injury, claimant is not entitled to an assessed attorney fee. We agree.

The apparent basis for the Referee's assessed attorney fee award is ORS 656.386(1). According to the Supreme Court, "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether claimant's condition was caused by an industrial injury, [former] ORS 656.386(1) is not the applicable attorney fee statute[.]" Short v. SAIF, 305 Or 541, 545 (1988). Subsequent to the Referee's order, we recently held that the 1991 amendments to the statute do not affect prior case law regarding its applicability. Gloria J. Shelton, 44 Van Natta 2232 (1992). Because this case concerns claimant's entitlement to temporary total disability, and there is no dispute

regarding the compensability of claimant's condition, we find that ORS 656.386(1) is not applicable and, therefore, cannot provide a basis for awarding an assessed attorney fee. Short v. SAIF, supra.

Moreover, we see no merit to claimant's argument that the insurer is somehow estopped from challenging the applicability of ORS 656.386(1) because it included language in its denial that claimant could be represented by an attorney of his choice "at no cost to [claimant] for attorney fees."

Although claimant is not entitled to an assessed attorney fee on the temporary disability issue, we conclude that he is entitled to an out-of-compensation attorney fee under ORS 656.386(2). See Esther C. Albertson, 44 Van Natta 523 (1992); Mona L. Allison, 43 Van Natta 1749 (1991). Accordingly, we approve an attorney fee of 25 percent of the increased compensation created by the Referee's order, not to exceed $1,050. OAR 438-15-045.

ORDER

The Referee's order dated February 28, 1992 is affirmed in part and reversed in part. The Referee's award of an assessed attorney fee of $2,800 is reversed. In lieu of the assessed attorney fee awarded by the Referee, claimant's attorney is awarded an out-of-compensation fee of 25 percent of the increased compensation created by the Referee's order, not to exceed $1,050, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

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February 11, 1993 Cite as 45 Van Natta 212 (1993)

In the Matter of the Compensation of
**MARGARET L. JONES, Claimant**
Own Motion No. 89-0032M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 23, 1992, Notice of Closure which closed her claim with an award of temporary disability compensation from February 28, 1991 through November 9, 1992. SAIF declared claimant medically stationary as of November 9, 1992. Claimant contends that she is entitled to additional benefits and requests we defer review of the own motion closure until an Opinion and Order issues in WCB Case No 89-03492.

The Board issued an order on January 26, 1989 reopening claimant's claim for temporary total disability compensation under our Own Motion authority. Nevertheless, we required closure under ORS 656.268 because her claim was reopened within the period for appealing from a prior Determination Order. On April 4, 1991 we issued an Own Motion Order Reviewing Carrier Closure and found that claimant's claim was not properly closed and remanded claimant's claim to SAIF for further processing to closure pursuant to ORS 656.268. See Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979); Rosemary J. Harrell, 42 Van Natta 639 (1990). Therefore, we need not defer our review of SAIF's Notice of Closure made pursuant to OAR 438-12-055 as it was not appropriate.

Inasmuch as claimant's claim was not properly closed, SAIF's November 23, 1992 Notice of Closure is set aside. Claimant's claim is remanded to SAIF for further processing to closure pursuant to ORS 656.268.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**BARBARA A. LUCKER, Claimant**
WCB Case No. 91-06716
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The self-insured employer requests review of Referee Podnar's order which set aside its "de facto" denial of the compensability of claimant's low back surgery. On review, the issue is compensability.

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

Inasmuch as the only medical opinions in the record indicate that claimant's current low back condition is directly related to the original, accepted injury of 1984, we find that the Referee correctly applied the material contributing cause standard in this case. Albany General Hospital v. Gasperino, 113 Or App 411 (1992); (See Exs. 46, 47). We agree with the Referee that, in order to prove compensability of her 1991 surgery for a herniated disc, claimant must establish that her original, 1984 injury was a material contributing cause of her need for treatment in 1991. ORS 656.245(1)(a); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993). After our review of the record, we find that claimant carried her burden and affirm the Referee's order.

The employer contends that claimant's current herniated disc is a secondary consequence of her accepted, 1984 low back condition. Therefore, the employer reasons that claimant must prove that her compensable 1984 injury was the major contributing cause of her disability and need for surgery in 1991. See ORS 656.005(7)(a)(A). We disagree. We have already found that the medical evidence establishes that claimant's 1991 need for surgery was directly related to her 1984 compensable injury. (Exs. 46, 47). There is no contrary medical opinion. Accordingly, we conclude that claimant's condition in 1991 was a direct, or primary, consequence of the 1984 injury, not a secondary consequence.

Moreover, even if we were to hold that the 1984 injury must be the major contributing cause of claimant's current condition in order for the 1991 surgery to be compensable, we would still find the surgery compensable. Claimant's treating doctors opined that her 1991 symptoms were directly related to the 1984 compensable injury. There is no other cause identified in the record. Claimant testified that the location and type of pain she experienced in 1991 was the same as the pain she experienced in 1984, only more intense and severe. (Tr. 19-20). Accordingly, since the 1984 injury is the only cause identified, we conclude that it was the major contributing cause of claimant's condition in 1991 and need for surgery.

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 compensability issue 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 June 30, 1992 is affirmed. Claimant's attorney is awarded $900 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
**HENRY L. STUDER, Claimant**
WCB Case No. 91-18057
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband, Kinsley, and Gunn.

The SAIF Corporation requests review of that portion of Referee Brazeau's order that awarded claimant temporary total disability benefits. On review, the issue is temporary total disability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's termination was not because of a violation of normal employment standards. Therefore, the Referee concluded that the job offer had been "withdrawn" pursuant to OAR 436-35-030(4)(b). Thus, the Referee found that claimant was entitled to temporary disability compensation. We disagree.

OAR 436-60-030(4)(b) requires the resumption of temporary total disability benefits if a modified job offer is withdrawn. That provision also provides that discharging a worker for violation of normal employment standards is not a withdrawal of a job offer. Id.

Although OAR 436-60-030(4)(b) affirmatively states that a violation of normal employment standards is not a withdrawal of a job offer, it does not address the opposite situation, i.e., whether termination allegedly without justification is a withdrawal of a job offer. Here, the employer prohibited personal use of a toll free number. However, claimant's son used the number to telephone claimant. Moreover, subsequent to the Referee's order, in Stone v. Whittier Wood Products, 116 Or App 427 (1992), the court held that the reasons that a worker was terminated, so long as they were unrelated to the compensable injury, were not relevant to the issue of entitlement to temporary disability benefits.

In Stone, supra, the claimant returned to work following her injury at a wage greater than her at-injury wage. Thereafter, she was terminated from her job for absenteeism and alcoholism. The claimant contended that she was entitled to temporary disability benefits following her termination arguing that the Board was required to determine if her discharge was unlawful before it determined her entitlement to temporary disability benefits. The court disagreed and stated:

> "We do not agree that the Board must first determine whether a termination is in conformance with statutory provisions other than the Workers' Compensation Act before it can determine a claimant's entitlement to worker's compensation benefits. So long as a termination is not for reasons related to the injury and the worker is earning wages equal to or greater than those received at the time of the injury, there is no entitlement to temporary benefits after the termination date. Safeway Stores v. Owsley, 91 Or App 475 (1988)."

See also Dawes v. Summers, 118 Or App 15 (1993)(No temporary compensation due where lost wages were due to claimant being fired for reasons unrelated to the compensable injury).

Here, after claimant's return to work, he was earning wages that equalled or exceeded his at-injury wage. Moreover, regardless of the justification for claimant's subsequent termination, it was for reasons unrelated to his compensable injury. Accordingly, claimant is not entitled to temporary disability benefits. Dawes, supra; Stone, supra; Owsley, supra.

## ORDER

The Referee's order dated April 2, 1992, as reconsidered April 24, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that found that claimant was entitled to temporary

total disability compensation and awarded an out-of-compensation attorney fee from this increased compensation is reversed. The remainder of the order is affirmed.

**Board member Gunn dissenting.**

I disagree with the majority's conclusion for the following reasons.

First, as provided by OAR 436-60-030(4)(b) and embodied in Kati A. Hanks, 44 Van Natta 881, 882 (1992), "temporary partial disability compensation shall continue until the "job no longer exists or the job offer is withdrawn." Further, the majority, nor their reliance on Stone v. Whittier Wood Products, 116 Or App 427 (1992), is contrary to the aforementioned rule.

In the present case, claimant was offered a job as a dispatcher. (Tr. 11). Claimant reported to work for that job at the Tom Walker Trucking Company. However, at no time did the job as a dispatcher ever materialize. Claimant received money personally from Tom Walker, but he did not receive wages from the company. The evidence in the record also indicates that the money claimant received from Mr. Walker was for remaining on the job site in anticipation of a dispatch job potentially arising sometime in the future. (Tr. 11-16).

Therefore, based on the unrebutted facts of this case, I find that the dispatcher job offer was withdrawn by the employer at the moment that claimant showed for work and that work was not available. The fact that Mr. Walker decided to compensate claimant for remaining available on the job site for when, if ever, the dispatch job would become available and then could be legitimately offered to claimant, does not alter the finding that the job offer was effectively withdrawn at the point that there was no such job available. Further, at the moment that the job offer was no longer available, logically, the job also no longer existed.

Accordingly, claimant is entitled to temporary partial disability compensation commencing at the moment that when he showed up for employment at the Tom Walker Trucking Company, there was no such dispatch job in existence, and no job offer remained. See OAR 436-60-030(4)(b); Kati A. Hanks, supra; Stone v. Whittier Wood products, supra.

I also note, as relied upon by the majority, that the court in Stone, supra at 430, concluded that "so long as termination is not for reasons related to the injury and the worker is earning wages equal to or greater than those received at the time of injury, there is no entitlement to temporary benefits after the termination date." Further, the Referee found, and I agree, that claimant was not fired for a violation of normal employment standards. See Opinion at 4.

The record establishes that claimant was fired because the employer believed that claimant had given out the employer's 800 number to a family member. (Tr. 17). The record also establishes that this fact was an erroneous belief on the employer's part. (Tr. 18). Further, the employer declined to correct his belief on the matter. (Tr. 17). In addition, there was absolutely no evidence that the Tom Walker Trucking Company had a company policy, or that claimant was informed of one, which addressed the use of the employer's 800 number. Therefore, I conclude that the employer's reason for terminating claimant was not for a violation of a company policy. Moreover, even assuming that it is a normal employment standard that nonemployees are not allowed to call into companies on their publicly available 800 numbers, I further conclude that claimant did not violate any such standard, because claimant was not the person who used the 800 number in that manner.

Accordingly, inasmuch as claimant was not fired for violating a company policy or a normal employment standard and there is no other reason for his termination elucidated in the record, in the alternative, I would remand this case to the Referee for the fact finding procedure of determining why claimant was fired. Then I would proceed to determine if the reason for his termination was related to his compensable injury and thus, if he is entitled to to temporary partial disability compensation.

For these reasons, I dissent.

In the Matter of the Compensation of
**MARKUS M. TIPLER, Claimant**
WCB Case No. 91-17279
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Phillip Nyburg, Defense Attorney

Reviewed by the Board en banc.

The insurer requests review of Referee Livesley's order that: (1) directed it to pay to claimant accrued interest on an approved attorney fee award which, as part of claimant's increased award of permanent disability benefits, was stayed pending appeal; and (2) awarded claimant's counsel an assessed attorney fee. In his brief, claimant disagrees with those portions of the Referee's order that: (1) directed the insurer to pay claimant the additional interest, rather than awarding it directly to claimant's counsel; and (2) declined to award a penalty pursuant to ORS 656.262(10) for the insurer's allegedly unreasonable failure to pay interest on the approved attorney fee. On review, the issues are interest on stayed compensation and penalties and attorney fees. We affirm in part, modify in part and reverse in part.

## FINDINGS OF FACT

The parties stipulated at hearing to the following facts.

On February 5, 1991, an Opinion and Order increased claimant's permanent partial disability award by $3,697.50. Board review was requested and payment of the additional compensation was stayed under ORS 656.313(1)(A). On September 30, 1991, a final Order on Review was entered finding the stayed compensation payable.

The calculated amount of interest on the stayed compensation of $3,697.50 at the rate of 9 percent per annum as prescribed by ORS 82.010 for the period of the stay is $241.85. The insurer has paid to claimant interest in the amount of $195.96, which is approximately 75% of the total calculated interest amount. The amount in dispute is $61.71.

## CONCLUSIONS OF LAW AND OPINION

### Interest on Stayed Compensation

We agree with the Referee that the insurer is required to pay interest on the entire permanent disability award which was stayed pending review, including the portion of the award which represented an out-of-compensation attorney fee. We adopt the Referee's Conclusions of Law and Opinion on that issue with the following supplementation.

The Court of Appeals recently considered the question whether the portion of a permanent disability award that is paid to claimant's attorney retains its character as compensation. In Steiner v. E.I. Bartells Co., 114 Or App 22 (1992), the court held that the portion of the award allowed as a fee is compensation to the claimant. The court reasoned:

> "Attorney fees are payable under the workers' compensation law either by the employer, in addition to any compensation, ORS 656.382(1); ORS 656.386(1); ORS 656.390, or by the claimant, from the compensation awarded. ORS 656.386(2). In the latter circumstance, attorney fees for a claimant's counsel remain the claimant's responsibility. They may be paid out of compensation that claimant receives or from some other source. The fact that the amount allowed is paid by an administrative process directly to the attorney does not change the character of the money as compensation paid to the claimant * * *. There was an award of permanent partial disability benefits and an authorization by the referee for claimant's attorney to charge a certain amount for his services."

Here, in accordance with ORS 656.313, the insurer was authorized to stay the payment of the additional permanent disability benefits awarded by the referee. However, ORS 656.313(1)(b) provides that such benefits shall be paid with interest thereon if "ultimately found payable under a final order." In light of the court's decision in Steiner, which holds that an out-of-compensation attorney fee retains its character as compensation, we conclude that the insurer was required to pay interest on the entire permanent disability award. We, therefore, affirm the Referee's conclusion on this isssue.

The Referee next concluded that that the entire accrued interest on the compensation awarded to claimant should be paid directly to claimant, rather than a portion to claimant's attorney. We disagree.

We conclude that the interest payment requirement of ORS 656.313(1)(b) protects a claimant's interest in the value of the prior award, during the time that award is being appealed. However, the interest provisions of ORS 656.313(1)(B), in and of themselves, do not increase the compensation made payable to claimant. Rather, those provisions replace the value that has been lost during the time the award was appealed; i.e., the time during which claimant would have been entitled to the award, had it not been stayed. Consequently, the interest is not an additional amount due, but is rather an amount which preserves the real monetary value of the compensation award. It should, therefore, be treated as part of the award itself.

In the present case, our September 30, 1991 Order on Review provided that claimant's attorney was awarded a reasonable approved fee of 25 percent of the additional compensation which resulted from our order, payable "directly to claimant's attorney." Accordingly, we conclude that, pursuant to the terms of our order, claimant's counsel is also entitled to 25 percent of the interest accrued following the prior Referee's order. We, therefore, modify that portion of the Referee's order which found that the entire accrued interest amount should be paid to claimant. Rather, the insurer is directed to pay claimant's counsel 25 percent of the accrued interest, with the remainder of the accrued interest to be paid to claimant.

Penalties and attorney fees

The Referee concluded that the insurer's actions were unreasonable, but because the compensation upon which the penalty would be based was the result of an Order on Review, claimant could not be awarded a penalty pursuant to ORS 656.262(10). We do not agree with the Referee's reasoning on this issue, and furthermore, in this case we do not find that the insurer's conduct was unreasonable.

In arriving at our above conclusion that the insurer was required to pay interest on claimant's award, we have relied upon the Steiner case, supra, which issued subsequent to the insurer's determination that it was not required to pay such interest. Moreover, in support of its argument that attorney fees are not part of claimant's compensation, the insurer has relied upon the case of Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Although we find Dotson to be distinguishable from the present case, we nonetheless conclude that the case could have raised a legitimate doubt with regard to the insurer's duty to pay the accrued interest. Further, the interest payment provisions of ORS 656.313(1)(b) are relatively recent. That statute does not address the issue we have decided here, nor is there a specific administrative rule that would guide the parties and, until this order issued, there was no published case interpretation as to the proper method of payment of accrued interest. Under such circumstances, we do not find the insurer's conduct to have been unreasonable.

In his order, the Referee awarded an assessed attorney fee for services at hearing concerning the insurer's allegedly unreasonable conduct. We have above concluded that the insurer's conduct, in this case, was not unreasonable. The Referee's assessed attorney fee award is, therefore, reversed.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of the amount of interest to be paid on his permanent disability award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $300 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. We note that no attorney fee is available for that portion of claimant's brief devoted to the penalty and attorney fee issues.

ORDER

The Referee's order dated March 23, 1992 is affirmed in part and reversed in part and affirmed in part. The Referee's assessed attorney fee of $650 for services concerning the insurer's allegedly unreasonable conduct is reversed. That portion of the Referee's order which directed the insurer to directly pay claimant the entire amount of interest accrued is modified. The insurer is instead directed to pay 25 percent of the accrued interest directly to claimant's attorney, with the rest of the accrued interest to be paid to claimant. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $300, to be paid by the insurer.

**Board Members Brazeau and Moller concurring in part and dissenting in part.**

We agree with that portion of the majority decision which concludes that the insurer was required to pay interest on claimant's entire permanent disability award which was stayed pending appeal. However, we would conclude that the insurer's failure to pay interest on the entire award was unreasonable and, therefore, would assess a penalty payable by the insurer. Further, we do not agree with the majority's conclusion that claimant's counsel -- rather than claimant himself -- is entitled to receive the accrued interest on the stayed award of compensation.

Turning first to the issue of the proper recipient of the unpaid interest, we note that attorney fees in workers' compensation cases are limited to those authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). Here, the award of an attorney fee at the prior extent-of-disability hearing was authorized by ORS 656.386(2), which provides for attorney fees to be paid "from claimant's award of compensation." Further, ORS 656.388(1) provides that "[n]o claim or payment for legal services by an attorney representing the worker * * * shall be valid unless approved by the referee or board * * *." Claimant's "award of compensation" was an additional 36 degrees of permanent scheduled disability, or $3,697.50. The Referee approved an attorney fee for claimant's counsel of "25% of said additional compensation * * *." Therefore, in accordance with ORS 656.386(2) and ORS 656.388(1), the approved attorney fee resulting from claimant's counsel's services at hearing was 25 percent of $3,697.50.

The majority concludes, however, that the subsequently accruing interest is part of the award itself. The majority further notes that, on Board review, we authorized an "approved fee of 25 percent of the additional compensation resulting from this order, payable directly to claimant's attorney." The majority then concludes that, pursuant to the terms of our order, claimant's counsel is also entitled to 25 percent of the interest accrued following the prior Referee's order. We do not agree.

On Board review, we increased claimant's scheduled permanent disability an additional 3 percent beyond that awarded by the Referee. Therefore, the "additional compensation" resulting from our order was 3 percent scheduled permanent disability. Contrary to the majority's inference, our attorney fee award neither replaced the attorney fee award made by the Referee nor provided a separate authorization for receipt of 25 percent of the accrued interest. This is reflected in that portion of our order which stated that claimant's "total out-of-compensation fee awarded under the Referee and Board orders shall not exceed $3,800." (Emphasis supplied.)

Moreover, in Steiner v. E.J. Bartells Co., 114 Or App 22 (1992), cited by the majority, the court stated that such an ORS 656.386(2) fee "may be paid out of compensation that claimant receives or from some other source." Accordingly, if claimant had so desired, he could have paid the fee allowed by the Referee irrespective of the employer's appeal. It follows that the interest accruing on claimant's award of compensation goes to claimant.

Therefore, considering the court's opinion in Steiner, as well as the language of ORS 656.386(2) and ORS 656.388(1), we conclude that claimant is entitled to be paid the entire interest accrued on his award of benefits. This conclusion comports with the intent of the legislature as expressed in the legislative history to the effect that the injured worker receive the interest accruing on compensation stayed pending an unsuccessful appeal. See Comments of Ross Dwinnell, Special Interim Committee on Workers' Compensation, May 3, 1990.

Next addressing the penalty issue, we disagree with the majority's conclusion that the insurer's refusal to pay interest on the entire award was reasonable. The majority finds that the insurer's conduct was not unreasonable because the court's decision in Dotson v. Bohemia Inc., 80 Or App 233 (1986) could have raised a legitimate doubt with regard to the insurer's duty to pay the accrued interest. In addition, the majority notes that Steiner was not issued until after the insurer's conduct occurred. First, with regard to Dotson, we note that the Referee expressly stated that the insurer failed to provide any case support for its conclusion that it need not pay interest on that portion of the award which was allowed as an out-of-compensation attorney fee. Thus, it is merely speculation to presume that the insurer relied on Dotson in reaching its decision not to pay the entire interest. Second, the court only restated in Steiner what it had previously stated in SAIF v. Gatti, 72 Or App 106 (1985), i.e., that an out-of-compensation attorney fee retains its character as compensation to the claimant.

More fundamentally, Dotson could be argued to provide support for the conclusion that the 25 percent attorney fee award was not compensation so that no interest need be paid on that amount. However, if the insurer believed that Dotson supported such a conclusion, then it follows that the attorney fee award likewise did not amount to compensation which could be stayed pending appeal. Instead, the insurer concluded that the award was "compensation" which could be stayed under ORS 656.313(1)(a) but that the award was not "benefits withheld" under ORS 656.313(1)(b). Such a contention is, on its face, clearly inconsistent and unsupported by any reasonable interpretation of the statute. The insurer cannot have it both ways. Having decided that the entire award was compensation (a conclusion supported by the court's recent decision in Steiner, supra), the insurer had no legitimate doubt as to its liability for the payment of interest accrued on the entire award. The Referee properly concluded that the insurer's conduct was unreasonable. A penalty should be imposed under ORS 656.262(10).

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In the Matter of the Compensation of
**RONALD CAMERON, Claimant**
WCB Case No. 91-07681
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

The insurer requests review of those portions of Referee Neal's order which: (1) directed it to pay claimant's total scheduled permanent disability award at the rate of $305 per degree; and (2) found that claimant was entitled to temporary disability benefits from July 16, 1990 to December 24, 1990. Claimant cross-requests review of those portions of the order that: (1) increased his scheduled permanent disability award from 39 percent (58.50 degrees), as awarded by an Amended Order on Reconsideration, to 43 percent (64.50 degrees); and (2) declined to assess a penalty and related attorney fee for the insurer's allegedly unreasonable failure to pay claimant's scheduled permanent disability award at the $305 per degree rate. In his brief, claimant contends that the "standards" applied by the Referee are invalid. On review, the issues are extent and rate of scheduled permanent disability, penalties and attorney fees, and extent of temporary disability benefits. We affirm in part, modify in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referees "Findings of Fact," except for the third finding in the "Ultimate Findings of Fact" section.

## CONCLUSIONS OF LAW AND OPINION

### Extent of Permanent Disability Benefits.

In awarding claimant an additional 4 percent scheduled permanent disability for loss of use or function of his left forearm, the Referee applied the temporary standards for rating permanent disability which were in effect at the date of claim closure, i.e., WCD Admin. Order 15-1990 adopted effective October 1, 1990. On review, claimant argues that the temporary standards applied by the Referee are invalid because they were improperly promulgated. He further argues that, if the temporary rules are set aside, he is entitled to a 5 percent rating for a chronic condition limiting repetitive use of his left hand and forearm.

Subsequent to the Referee's order, we addressed the applicability of the temporary standards in Eileen N. Ferguson, 44 Van Natta 1811 (1992). There, the claimant urged us to give no effect to those standards, which she contended were adopted in violation of the required rulemaking procedures, and to recalculate the extent of permanent disability under the previous standards. We rejected that argument, holding that our review of the extent issue is limited to the standards that were adopted by the Director at the time of the issuance of the Determination Order. Id.

Therefore, in accordance with Ferguson, we reject claimant's argument and find that the temporary standards set forth in WCD Admin. Order 15-1990 apply to this case. See also Edmunson v. Dept. of Insurance and Finance, 314 Or 291 (1992).[1] Under those standards, claimant is not entitled to an additional 5 percent rating for chronic condition limiting repetitive use of his left hand and forearm. See former OAR 436-35-010(6).

Claimant also contends that, under former OAR 436-35-200, he is entitled to a 6 percent rating in each foot for changes in plantar sensation. In support of his contention, claimant cites only his testimony at hearing. However, the standards provide that all disability ratings are to be "established on the basis of medical evidence supported by objective findings" from the attending physician. Former OAR 436-35-010(1). Here, claimant's attending physician indicated that claimant had no plantar sensation changes in his feet. (Ex. 18-16). Therefore, we concur with the Referee that there is no objective medical verification of impairment. Accordingly, we affirm and adopt the Referee's order in this regard.

Rate of Payment of Permanent Disability Award.

Relying on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), the Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree.

In Alan G. Herron, supra, we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. However, the Court of Appeals has recently reversed our decision, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Penalties and Attorney Fees

The Referee also concluded that the insurer's failure to pay claimant's permanent disability at the $305 per degree rate was not unreasonable given the June 12, 1991 Amended Order on Reconsideration directing it to pay a sum equivalent to $145 per degree. We agree. See Mary E. Weaver, 43 Van Natta 2618 (1991).

Extent of Temporary Total Disability Benefits

The Referee found that Dr. Bitseff, claimant's attending physician, had released claimant to return to work on July 16, 1990, but did not inform him that he was released to return to work until December 24, 1990 and never provided him with a written work release. Therefore, relying on ORS 656.268(3), the Referee concluded that claimant was entitled to additional temporary total disability benefits (TTD) from July 16, 1990 to December 24, 1990.

In reaching her conclusion, the Referee noted an apparent inconsistency between ORS 656.262(4) and ORS 656.268(3). Additionally, the insurer argues on review that it properly terminated claimant's TTD under ORS 656.262(4), because TTD was not authorized by the attending physician and, therefore, was not owed for that period of time. Consequently, before turning to the merits, we first address the Referee's perceived inconsistency between ORS 656.268 and ORS 656.262(4). In doing so, we note that,

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[1] The dissent asserts that we not only can, but must address the validity of the Department's temporary rules in order to comply with our own permanent administrative rule, OAR 438-10-010. Our rule provides for the application of the Department's rules "in effect" on the date of (in the present case) claimant's Determination Order. The dissent asserts that in order to determine whether the Department's rules were "in effect," we must determine whether they were validly enacted.

We disagree. Rather, we are bound by our holding in Ferguson, supra, that our authority is limited to determining the validity of our own rules. If our OAR 438-01-010 is valid, we are authorized to determine solely whether the Department's rules were "in effect," i.e., existed, on the date claimant's Determination Order issued. The Department's rules "existed" if they had, in fact, been promulgated by the Department as of the date of the Determination Order. Whether they were validly promulgated is a different matter, and is one over which we have no authority pursuant to our decision in Ferguson.

where there is an apparent inconsistency between provisions of a statute, it is our duty to harmonize them if possible. See Norton v. State Compensation Dept., 252 Or 75 (1968).

ORS 656.268(3) provides that TTD shall continue until whichever of three specific events first occurs: (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. ORS 656.268(3)(a), (b), and (c). We have previously interpreted ORS 656.268(3) to allow the insurer or self-insured employer to unilaterally terminate a claimant's TTD when one of those specific events occurs, regardless of whether the claimant is medically stationary. See Soledad Flores, 43 Van Natta 2504 (1991).

ORS 656.262(4)(b) provides that temporary disability compensation is not due for periods of time where the insurer has requested verification and the attending physician does not do so, unless the claimant was unable to receive treatment for reasons beyond the claimant's control. We have interpreted ORS 656.262(4)(b) to provide a mechanism whereby an insurer or self-insured employer may unilaterally terminate a claimant's TTD when there is a continuing request for benefits and the insurer meets certain requirements. See Joel O. Sandoval, 44 Van Natta 543 (1992); Sandra L. Masters, 44 Van Natta 1870 (1992). First, the insurer must have requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease. Joel O. Sandoval, supra at 546. Second, the physician must be unable to verify the worker's inability to work. Id. The statute is applicable if these two requirements are met, unless the worker has been unable to receive treatment for reasons beyond the worker's control. See ORS 656.262(4)(b).

Following our review of these two provisions, we find that they are not inconsistent. We find that both ORS 656.268(3) and ORS 656.262(4)(b) provide for orderly processing of claims by allowing insurers or self-insured employers to unilaterally terminate TTD under certain narrow circumstances and if certain specific requirements are met. Moreover, we find that ORS 656.262(4)(b) is applicable here.

Turning to the merits, we first note that there is no evidence that claimant was unable to receive treatment for reasons beyond his control. Claimant testified that he saw Dr. Bitseff in July and December 1990. (Tr. 9). Additionally, Dr. Bitseff's chart note indicates that claimant missed another appointment set for October 26, 1990. (Ex. 14). Moreover, we find that the supplemental medical report (Form 828) dated September 17, 1990 (Ex. 15), which was to be completed by Dr. Bitseff and returned to the insurer, constitutes a request for verification of claimant's inability to work resulting from his injury. We further find that, because Dr. Bitseff indicated in the report that claimant was medically stationary and able to work as of July 16, 1990, Dr. Bitseff was unable to verify claimant's inability to work past that date.

Claimant has the burden of establishing entitlement to TTD for the period in question. See ORS 656.266. Based on these facts, claimant has failed to carry his burden. Consequently, we conclude that TTD was not due and payable after July 16, 1990. We reverse the Referee's order accordingly.

## ORDER

The Referee's order dated September 26, 1991 is reversed in part, modified in part and affirmed in part. That portion of the order which directed the insurer to pay claimant's scheduled permanent disability award at the $305 rate and awarded an out-of-compensation fee payable from this increased compensation is reversed. That portion of the order which found that claimant was entitled to temporary disability compensation benefits from July 16, 1990 to December 24, 1990 and awarded an out-of-compensation attorney fee payable from this increased compensation is reversed. The remainder of the order (including the 4 percent increased scheduled permanent disability award and out-of-compensation attorney fee payable from that increase) is affirmed.

**Board Member Hooton dissenting.**

This case involves several interesting questions on review. The simplest among them is the question of the amount at which claimant's scheduled disability award is to be paid. With the decision of the Court of Appeals in SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992), we are without

authority to award claimant the amount of $305 per degree. I have no dispute with the majority resolution on this issue, even though the reasoning of the Court of Appeals is less than persuasive in light of the requirement the Workers' Compensation Law be liberally construed in favor of the injured worker. Reynaga v. Northwest Farm Bureau, 300 Or 255, 262 (1985).

The claimant has requested that we invalidate the temporary rules and allow an additional award of scheduled disability under the permanent rules adopted January, 1989. If the temporary rules adopted in October 1990 are invalid, the preceding permanent rules are the rules appropriately applicable to this claim. On the resolution of this matter, I do disagree with the majority's reasoning and conclusions.

The majority argues that we resolved this question adverse to claimant in Eileen N. Ferguson, 44 Van Natta 1811 (1992). The majority is wrong. In that case, over my dissent, we determined only that we are without authority to invalidate the temporary rules, not because the rules were valid, but because we were not the "agency" and therefore lacked the authority to review the validity of the rules. I will not again address the facetiousness of that conclusion, but refer the parties to my dissent in Ferguson.

Since that time, the Supreme Court has had occasion to consider the validity of the temporary rules in Edmundson v. Dept. of Ins. and Finance, 314 Or 291 (1992). The Court also declined to determine whether the rules were improperly enacted and, therefore, invalid. The Court explained that the temporary rules ceased to exist with the adoption of permanent rules, and continued to be applicable, if at all, only by virtue of the terms of the permanent rules. Those rules require claimant's permanent partial disability to be rated pursuant to the rules "in effect"[1] on the date of the Determination Order or Notice of Closure. Id. @ 295.

With regard to the rules applicable at hearing on the question of extent of disability, this Board has adopted OAR 438-10-010 which provides for application identical with that specified by the Department. In this case, unlike Ferguson, we determine the application and effect of our own rule, and only through it, the rules of another agency. Therefore, if the temporary rules were "in effect" on the appropriate date, they remain applicable to this claim under the express terms of OAR 438-10-010. However, if the temporary rules were not "in effect", that same rule requires the application of the preceding permanent rules adopted in January, 1989. We cannot avoid considering the validity of the temporary rules based on the specious argument that we are not the "agency", because we are, in fact, the agency responsible for the adoption of OAR 438-10-010.

As the body responsible for the explication and application of the permanent rules, and unquestionably, the agency responsible for the content as well as the explication and application of OAR 438-10-010, the Board and its Hearings Division must determine what rules were "in effect" on the date of the Determination Order in this claim. In order to accomplish this, we must determine whether the temporary rules were validly enacted. If the temporary rules were not validly enacted, they could not be "in effect" on the date of the Determination Order in this claim. Because the Statements of Need and Adoption for the temporary rules do not meet the requirements of statute, the temporary rules were never "in effect" as that term is used in the current administrative rules governing the determination of permanent partial disability compensation. The failure of the majority to consider whether the temporary rules were "in effect" on the date of the Determination Order, as required by the Supreme Court's interpretation of the subsequently adopted permanent rules, is in error.

In addition to the question of the extent of claimant's permanent partial disability, the insurer argues that claimant is not entitled to temporary disability compensation after July 16, 1990. The majority erroneously concludes that ORS 656.262(4) requires the termination of temporary disability benefits on that date. Again, the majority errs.

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[1] The majority argues that a rule is in effect if it exists. The majority has failed to consider the statutory procedures at ORS 183.325 to 183.355. Those statutes frequently declare that rules are not "effective" unless the procedures of adoption are followed. Existence and effectiveness are not synonymous.

The majority states that claimant is not entitled to temporary disability benefits after July 16, 1990 because the attending physician released him to his regular employment on that date and, therefore, is unable to verify additional disability under ORS 656.262(4)(b). The majority further argues that its interpretation of ORS 656.262(4)(b) is not inconsistent with the provisions of ORS 656.268(3)(b).

ORS 656.268(3) provides, in pertinent part, as follows:

> "Temporary total disability compensation shall continue until whichever of the following events first occurs:
>
> "* * *
>
> (b) "The attending physician gives the worker a written release to return to regular employment."

In the present claim, the undisputed fact is that claimant did not receive a written release for regular work. He did not even receive a verbal release. The attending physician told the insurer, after the fact, but neglected to tell anyone else. Under the clear, unambiguous and mandatory terms of ORS 656.268(3)(b), this claimant is entitled to receive temporary disability until he receives a written release. The insurer is not entitled to terminate the payment of temporary disability compensation on July 16, 1990.

The majority concludes that the insurer is so entitled under the terms of ORS 656.262(4)(b), reasoning that after the attending physician determined that claimant was capable of performing regular work on July 16, 1990, that physician was no longer able to verify disability. In other words, even though a written release is required to terminate the payment of temporary disability compensation under ORS 656.268(3)(b), that requirement is rendered meaningless by the majority's interpretation of ORS 656.262(4)(b). The majority then states that ORS 656.268(3)(b) and ORS 656.262(4)(b) are not inconsistent. Given the obvious inconsistency, I am not convinced. Consequently, I must reject the interpretation of ORS 656.262(4)(b) offered by the majority.

It is a long standing and well-established principle of statutory construction that, where statutes are apparently inconsistent, they are to be construed, wherever possible, in a manner that gives complete effect to both. State v. Gourley, 209 Or 363, 377 rehearing den. 209 Or 363 (1957). See also, Springstead v. Lincoln Cas. Ins. Co., 232 Or 179, 183 (1962). The majority's conclusion that ORS 656.268(3) and ORS 656.262(4) (as the majority construes it) are not inconsistent is sophistry to avoid the necessity of limiting the scope of ORS 656.262(4) so as to give effect to the mandatory provisions of ORS 656.268(3).

In reality, ORS 656.262(4) is not inconsistent with ORS 656.268(3) because ORS 656.262(4) doesn't mean at all what the majority asserts that it means. ORS 656.262(4) provides in pertinent part as follows:

> "(a) "The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Thereafter, compensation shall be paid at least once each two weeks...
>
> "(b) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.
>
> "(c) If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after that worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend the payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment."

ORS 656.262(4)(b) cannot be applied without first meeting the requirements of ORS 656.262(4)(c). The two provisions must be read together to avoid rendering the final clause of ORS 656.262(4)(b) absurd.[2] That clause is a relief provision from the punitive allowances of the first portion of that statute. However, the relief provision does not mirror any of the remaining provisions of the subsection and appears to presume specific preconditions to suspension of time loss benefits not included within the express language of the subsection. Those preconditions do appear at subsection (c) and, by reading the two subsections together, the whole is consistent and clear.

Subsection (b) permits the insurer or self-insured employer to suspend the payment of time loss benefits where claimant has missed an appointment with the attending physician, and where, because of that missed appointment, the attending physician is unable to verify continued disability. Before the insurer or self-insured employer may suspend the payment of temporary disability compensation, however, it must first request verification and receive notice that the claimant failed to keep a scheduled appointment with the attending physician, and as a consequence, the physician is unable to verify continued disability. Thereafter, the insurer must schedule an appointment and notify the claimant by certified mail of the rescheduled appointment, and of the insurer's right to suspend the payment of time loss benefits if the claimant fails to keep the rescheduled appointment. If the claimant fails to keep the rescheduled appointment, the insurer still may not suspend the payment of time loss benefits if the failure to keep the rescheduled appointment is not the fault of the claimant.

This interpretation accomplishes the result intended by the legislature in providing the insurer or self-insured employer a means of suspending time loss benefits in certain circumstances without obtaining the prior approval of the Director pursuant to ORS 656.325(2) through (4). The fulfillment of the requirements of ORS 656.262(4)(c) completes the notice and due process requirements established for similar acts taken by the Director under ORS 656.325. See Carr v. SAIF, 65 Or App 110 (1983), rev dism 297 Or 83 (1984).

This interpretation is consistent with the language and intent of ORS 656.262(4) without creating inconsistency with ORS 656.268(3). Both statutes are preserved in their entirety without conflict. In addition, this interpretation meets the long standing requirement deriving from the remedial nature of the Workers' Compensation Law that statutes are to be construed in favor of compensation wherever possible. Reynaga v. Northwest Farm Bureau, 300 Or 255, 262 (1985).

The majority interpretation of ORS 656.262(4)(b), taken, as it is, in isolation, has rendered meaningless the provisions and requirements of ORS 656.262(4)(c), has rendered absurd the relief provisions of ORS 656.262(4)(b) and creates an unnecessary conflict, or inconsistency, with the provisions of ORS 656.268(3). Finally, it wholly ignores the long standing principles of statutory construction which requires that remedial statutes be construed in favor of compensation and consistent with the constitutional protections of due process. No reasonable jurist could adopt such an interpretation. Therefore, with all due deference and respect, I dissent.

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[2] The absurdity that results from the majority's interpretation of ORS 656.262(4)(b) is readily apparent by modifying only slightly the facts of the present claim. The majority presumes that the insurer is entitled to terminate time loss whenever the attending physician is unable to verify an inability to work, regardless of the cause of that inability. There is an absolute relief provision, however, if claimant is unable to receive treatment through no fault of his own. If in the present claim, claimant's missed appointment occurred because of a traffic accident in which he was not at fault, the majority's interpretation would require us to find that the attending physician was unable to verify continued disability by virtue of his determination that claimant was capable of regular work, but that the insurer was not entitled to suspend time loss benefits because claimant was prevented from receiving treatment through no fault of his own, even though his inability to receive treatment has nothing to do with whether he is capable of performing his regular work. The statute only makes sense if the attending physician's inability to verify continued disability also derives from that missed appointment.

In the Matter of the Compensation of
**DANA J. FISHER, Claimant**
WCB Case No. 91-17438
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Hooton.

Claimant requests review of Referee Nichols' order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. 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 order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See 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). Furthermore, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

Here, the Referee found that, although claimant proved an increase in symptoms and diminished earning capacity, he failed to show that the worsening was more than waxing and waning of symptoms contemplated by the previous award of permanent disability. Furthermore, the Referee found that part of claimant's increased symptoms were due to difficulties with his employer rather than his compensable injury. Therefore, the Referee concluded that claimant had failed to prove a compensable aggravation. Claimant challenges this conclusion, asserting that he satisfied all the elements necessary to establish his aggravation claim.

Claimant was awarded 31 percent permanent disability by a June 1989 Determination Order. After experiencing an aggravation, a second Determination Order issued in March 1990 awarding no additional permanent disability. Claimant first contends that the June 1989 Determination Order, rather than the March 1990 Determination Order, constitutes the "last award or arrangement of compensation." We have held that the last arrangement of compensation is dated as of claimant's last opportunity to present evidence of his current condition. Frank L. Stevens, 44 Van Natta 60, 61 (1992). In this case, claimant's last opportunity to present evidence of his current condition was at the time of the March 1990 Determination Order. Therefore, that order constitutes the last arrangement of compensation.

Claimant next disputes that the previous award of permanent disability contemplated waxing and waning of symptoms. In order to show that a previous award of permanent disability contemplated waxing and waning of symptoms, there must be medical evidence existing at the time of the award predicting such flare-ups; it is not sufficient that claimant has a history of exacerbations. See Lucas v. Clark, supra, 106 Or App at 691. Here, we conclude that none of the medical evidence existing at the time of the March 1990 Determination Order predicted that claimant would experience waxing and waning of symptoms. At most, claimant's treating physician, Dr. Berkeley, neurological surgeon, agreed with the statement that claimant's aggravated condition prior to the March 1990 Determination Order was to be expected given claimant's degree of disability. (Exs. 65, 66). However, Dr. Berkeley did not indicate that claimant would continue to experience such exacerbations. Therefore, we agree with claimant that the March 1990 Determination Order did not contemplate waxing and waning of symptoms and, consequently, ORS 656.273(8) is not applicable.

The employer contends that claimant neither proved that his increased symptoms resulted from the industrial injury nor that he sustained diminished earning capacity. Specifically, the employer asserts that any increased symptoms were due to a labor dispute and the accompanying stress and that,

therefore, Dr. Berkeley's work release was not caused by a worsened condition resulting from the compensable injury.

Claimant was released from work in June 1991 by his family doctor due to an illness resulting from stress caused by employment performance problems. In July 1991, Dr. Berkeley also released claimant from work. Dr. Berkeley reported that claimant "started having increasing pain in the low back and in the hips about mid-April 1991 * * * and this essentially is an aggravation of his underlying condition for which he was treated surgically." (Ex. 77). Dr. Berkeley further reported that "the combination of stress that he has been under at work causing muscular spasms and contractions as well as re-aggravation of his back condition physically have caused persisting pain in the low back, muscle cramps and significant discomfort." (Id). In August 1991, claimant returned to work, limited to four hours a day.

A compensable worsening is proved by showing that the compensable injury was a material contributing cause of the worsening. Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if an off-the-job injury is the major contributing cause of the worsened condition, the worsening is not compensable. See ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992). Furthermore, it is the carrier's burden to prove that an off-the-job injury was the major contributing cause of the worsened condition. Roger D. Hart, 44 Van Natta 2189 (1992).

Here, although Dr. Berkeley indicated that claimant's employment dispute contributed to his symptoms, he also reported that claimant had experienced an aggravation of his previous injury, thereby also indicating that claimant's industrial injury was a material contributing cause of his increased symptoms. Furthermore, even if claimant's dispute with his employer could be considered an "off-the-job injury" under ORS 656.273(1), the employer failed to show that this event was the major contributing cause of claimant's worsening. Therefore, we conclude that claimant satisfied his burden of proving that his worsened condition resulted from his compensable injury.

Finally, we do not find that the IME report of Drs. Reimer, neurologist, and Fry, orthopedic surgeon, prevents claimant from establishing a compensable aggravation. Although their report stated that claimant did not sustain a material worsening of his underlying condition, it acknowledged that claimant experienced increased symptoms. (Ex. 82). As stated above, that is sufficient to prove a worsening.

In conclusion, we find that claimant showed that he sustained increased symptoms resulting in diminished earning capacity. Furthermore, we find that claimant showed that this worsening was caused in material part by his compensable injury. Finally, claimant need not show that this worsening was greater than any prior waxing and waning since the previous award of permanent disability did not contemplate any future exacerbations. Therefore, we conclude that claimant proved a compensable aggravation.

Claimant's attorney is entitled to an attorney fee for finally prevailing against the employer's denial. See 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 services at hearing and on review is $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 24, 1992 is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer.

**Board Member Hooton specially concurring.**

I agree with the result reached by Board Member Moller, but cannot support the reasoning by which he reached that result. The principal basis for disagreement is the weight to be accorded a doctor's prediction that a claimant's condition will wax and wane given the publication of revised rules

for the rating of impairment in and subsequent to October of 1990. With the revised rules the Director has made it functionally impossible to adjust an award of disability to account for predicted waxing and waning. The current standards provide set impairment awards based on objective findings that are immutable.

If we assume the existence of three claimants with identical impairment findings, and presume that the medical record predicts that one of those claimants will experience waxing and waning but that the periods of waxing and waning of symptoms causing temporary or total disability will not exceed two weeks; that another of those claimant's will experience waxing and waning causing periods of disability of up to two months; and, finally, that the third claimant will experience no waxing and waning at all, application of the current standards will provide exactly the same award for each of those claimants. Further, amendments to ORS 656.283(7) and ORS 656.295(5) have deprived the Board and the Hearings Division of the authority to make an award outside the standards that would compensate each of these claimants individually for their expected waxing and waning.

The statute in question requires that claimant prove that his "worsening is more than the waxing and waning of the condition contemplated by the previous permanent disability award." ORS 656.273(8). The focus of the statute is on the compensation which claimant has received, and appropriately so. The waxing and waning provision of the aggravation statute presumes that it is possible for claimant to be compensated for future lost earning capacity in his permanent disability award. If he is, and if that compensation for lost earning capacity considered waxing and waning of symptoms, allowing an aggravation claim with temporary disability compensation for that same waxing and waning of symptoms would doubly compensate claimant for the same loss. However, if the waxing and waning of symptoms was not considered in the permanent disability compensation but is allowed as a defense to an aggravation claim, then claimant experiences a loss of earning capacity as well as an actual loss of earnings for which he goes uncompensated.

While the statutory provision is sound, the evidentiary problem it created, prior to the amendments to the Workers' Compensation Law by the 1990 Special Legislative Session, was provocative. Settlements which recite that they are made in contemplation of waxing and waning typically do not specify the predicted period. The referee, who prior to July 1, 1990 had the capacity to award compensation outside the standards, also did not typically specify the period of waxing and waning contemplated by the award he allowed. Consequently, the question came before the Court of Appeals in Lucas v. Clark, 106 Or App 687 (1991). The Court concluded that medical evidence which predicted future flare ups gave rise to an assumption that waxing and waning was contemplated by the prior award. That assumption, however, is not appropriate in all cases. As the Court specifically stated:

> "...Since Gwynn we have said repeatedly 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." 106 Or App at 690."

In other words, in Lucas the Court created a presumption in favor of the insurer, that that waxing and waning is considered in the compensation awarded where the medical evidence indicates future anticipated waxing and waning. However, the presumption is rebuttable if claimant can demonstrate that it was not considered. Because the current standards do not consider waxing and waning in any form, and because there is no manner in which compensation can be adjusted by this forum or by the Hearings Division to account for waxing and waning, the only time when the presumption could possibly apply under the current state of the law is where the parties entered into a settlement agreement on permanent partial disability; where the settlement recites its reliance upon the waxing and waning of symptoms; and, where the compensation awarded exceeds that which would have been allowed by the standards based on the impairment findings of the treating physician or medical arbiter.

Because the Department has removed the possibility of compensation for waxing and waning, and since there is no evidence to support the conclusion that the parties reached an independent settlement agreement which contemplated waxing and waning in fact, a prediction of such waxing and waning in the medical record, even if it rose to the level of absolute certainty and specified precisely the

anticipated duration of disability, is irrelevant. Reliance upon the medical record for determination of this question is, therefore, inappropriate.

However, because claimant has not been compensated for any anticipated waxing and waning in his awards of compensation to date, I agree that claimant need not demonstrate that his current worsening exceeds the waxing and waning anticipated by any prior award.

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February 18, 1993 Cite as 45 Van Natta 228 (1993)

In the Matter of the Compensation of
**BRYAN A. FLORA, Claimant**
WCB Case No. 91-11278
CORRECTED ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

Claimant requests review of Referee Mongrain's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for an abnormal heart beat and hypertension. On review, the issue is compensability.

We affirm and adopt the order of the Referee, except that we do not find that the record establishes that claimant suffers from left ventricular hypertrophy, but that he does suffer from some type of myocardial disease.

ORDER

The Referee's order dated December 18, 1991 is affirmed.

**Board Member Hooton dissenting.**

This case involves an application of the firefighters presumption at ORS 656.802(4). Under the presumption, claimant's hypertension and cardiomyopathy alleged to be left ventricular hypertrophy is presumed to be compensable unless the employer can show, by clear and convincing evidence, that claimant's condition is not caused by his employment exposure. SAIF v. Bales, 107 Or App 198, 201 (1991). To be "clear and convincing," the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). The majority affirms and adopts the reasoning and findings of the Referee. The Referee explains his reasoning as follows:

> "Here, I must weigh four non-relationship opinions against one non-opinion and one non-opinion enhanced to a small degree by a "maybe". As I see it, non-relationship is highly probable, therefore clear and convincing, and the presumption is overcome and SAIF Corporation's denial must be approved." Opinion and Order of December 18, 1991, page 3.

I have absolutely no doubt that every judge who ever had to sort out conflicting evidence wished his task could be resolved by so simple a calculus. Unfortunately, the reasoning process here baldly mischaracterizes the evidence offered in the opinions of Dr. Morris and Dr. Kotler as a non-opinion and a non-opinion enhanced by a "maybe". In addition the Referee fails to analyze the reliability of the opinions offered by each of the medical experts involved. The weighing process is not a process of comparing numbers, but of evaluating evidence. See, e.g., Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986); Abbott v. SAIF, 45 Or App 657 (1980). The reasoning process utilized by the Referee, and adopted by the majority, does not meet the requirements of Armstrong v. Asten Hill, 90 Or App 200 (1988).

The opinions expressed by Dr. Kotler and Dr. Morris are not non-opinions as characterized by the Referee. Both of these physicians have expressed the opinion that it is not possible to determine with particularity the actual causes of claimant's hypertension. (Exs. 18 and 19, respectively). Dr. Morris goes further than Dr. Kotler and notes that there are many potential causes of hypertension, including family history, obesity and occupational stress. He argues that it is impossible to determine which of these factors account for claimant's condition. (Ex. 19). Dr. Morris' assertion that many factors might explain causation in any particular case is verified by Dr. DeMot who describes hypertension as "multifactorial." (Ex. 17.)

On the question of claimant's cardiomyopathy, Dr. Morris attributes causation to claimant's hypertension. (Ex. 19). The inability to sort out causation thus applies to the cardiomyopathy as well. Dr. Kotler, however, opines that the diagnosis of left ventricular hypertrophy is purely speculative because the necessary confirmatory tests have not been completed. (Ex. 18). If that is the case, any determination of causation based on the diagnosis of left ventricular hypertrophy is likewise speculative.

Dr. DeMot agrees with Dr. Kotler that ventricular hypertrophy can only be diagnosed via echocardiogram. Though the test was conducted, it was inconclusive on the diagnostic question. He further argues, however, that claimant does, without a doubt, suffer from a cardiomyopathy of some kind, rather than coronary artery disease. On the causation of this cardiomyopathy, however, he is only willing to say that it "may" be genetic in origin. (Ex. 17). This represents only a possibility. It does not rise to the level of a probability, and could not possibly constitute clear and convincing evidence on causation.

Given the clear and concise explanations of both Dr. Kotler and Dr. DeMot that left ventricular hypertrophy cannot be diagnosed on the basis of this record, the opinions of Dr. Morris and Dr. Toren on the causation of claimant's coronary condition, both of whom speculate that the diagnosis is, in fact, ventricular hypertrophy, are fully impeached and, therefore, worthless. Neither doctor indicates the basis for his diagnosis nor disputes or clarifies the statements of Drs. Kotler and DeMot regarding the significance of an echocardiogram.

Dr. DeMot and Dr. Toren, in customary fashion, conclude that claimant's employment did not cause his hypertension. (Exs. 17 and 16, respectively). Dr. Toren, however, has demonstrated himself willing to indulge in forensics based solely on speculation with regard to claimant's cardiomyopathy. The reliability of his opinion is, therefore, substantially in doubt. I am unable to determine any basis for concluding that his opinion is likely to be more reliable on the hypertension question than it is on the issue of the causation of claimant's cardiomyopathy.

Dr. DeMot concludes that there is no statistical evidence that would link hypertension to claimant's occupational exposure, noting specifically that physical exercise is prescribed in the treatment of hypertension. (Ex. 17). However, physical exertion is not the only element of claimant's occupational exposure. Claimant's job also involves a lot of stress, and exposure to noxious fumes. Stress and physical exercise are not the same thing. Indeed, physical exercise is also recommended therapy for stress reduction. Neither Dr. DeMot nor Dr. Toren attempt to explain the causal implication of claimant's exposure to noxious fumes and carbon monoxides as a consequence of his occupation as a firefighter, and therefore, by definition, any explanation in support of their conclusion that claimant's occupation did not contribute to causation is incomplete. If the appropriate standard of proof were the preponderance of the evidence, the insurer may have produced enough evidence to carry that burden in these incomplete reports. However, that is not the burden, and an incomplete analysis is not "clear and convincing" evidence of anything.

In addition, a review of Dr. Toren's causal statements regarding hypertension indicate that, along with Dr. DeMot, he concludes that hypertension is of unknown origin but is not related because of its statistical prevalence in the population at large. That analysis is inappropriate. In Ingram v. SAIF, 72 Or App 215, 218, rev den 299 Or 313 (1985), the Court of Appeals noted that "[c]laimant is correct in his assertion that a diagnosis that a condition is idiopathic is not evidence under ORS 656.802(2) that the

condition is unrelated to the fireman's employment."[1] Further, the proported statistical analysis is of questionable significance in light of Stedman v. Garrett Freightlines, 67 Or App 129 (1984).

On this record, I cannot find that Dr. DeMot and Dr. Toren presented clear and convincing evidence that claimant's occupation did not cause his hypertension and cardiomyopathy. Even if we conclude, however, that claimant's hypertension is not caused by his employment there is no reliable evidence which excludes claimant's occupation as a cause of the cardiomyopathy condition.

On this record, the presumption of ORS 656.802(4) has not been rebutted and SAIF Corporation's denial of compensability must be set aside.

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[1] The reference to statute is to former ORS 656.802(2). That provision is now located at ORS 656.802(4). In addition, it is important to note that while the Courts discussion of the law in Ingram remains valid, its weighting of the evidence does not. In 1983 the legislature amended the firefighter's presumption to include a clear and convincing evidence requirement which was not effective in Ingram. Consequently, evidence which would have been sufficient to carry the employer's burden in that case is not longer sufficient.

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In the Matter of the Compensation of
**ANN M. MASTERTON, Claimant**
WCB Case No. 91-17131
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Terrall, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee Nichols' order which set aside its denial of claimant's occupational disease claim for a right foot condition. The employer has also moved to remand this case to the Referee for further evidence, based on new evidence submitted with its appellant's brief. On review, the issues are remand and compensability. We deny the motion and affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Remand

The employer moves to remand this case to the Referee for the taking of additional evidence, based on the affidavits of its employees. The affidavit of the employer's payroll coordinator, Chris Pohrman, alleges that claimant told Ms. Pohrman in late September 1991 that she (claimant) was going to have herself put on the payroll because she had injured her foot and needed workers' compensation coverage in order to get treatment. The conversation allegedly took place before claimant was on the payroll. The affidavit of Kevin Priest, the employer's manager, alleges that he did not discuss claimant's claim with Ms. Pohrman until after the hearing had been held, at which time Ms. Pohrman told him of her late September 1991 conversation with claimant. The employer asserts this is material evidence tending to establish that claimant's foot condition preexisted her employment by the employer, and was not obtainable with the exercise of due diligence at the time of the hearing.

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 clearly be 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. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

Here, we find that the evidence the employer now seeks to admit was obtainable with the exercise of due diligence at the time of the hearing. The conversation with the employer's payroll coordinator took place in late September 1991, approximately 2-3 weeks before claimant advised Mr. Priest of her right foot problem. (See Ex. A). At that time, Mr. Priest indicated on the accident report form that "[e]mployee has had this foot problem for some time, before our payroll service began." (Ex. A). We find that the employer knew of a possible preexisting foot condition at the time claimant filed her claim, which should have prompted the employer to fully investigate the issue prior to hearing. The employer admits that the evidence was available prior to hearing, and we find that it was also obtainable with the exercise of due diligence.

Moreover, we do not consider the present record, without the testimony of Ms. Pohrman, to be improperly, incompletely, or insufficiently developed concerning the issue of compensability. The present record establishes the possibility of a foot condition which preexisted claimant's workers' compensation coverage. Therefore, we do not find that the proferred evidence is likely to affect the outcome of the case. For these reasons, the employer's motion to remand is denied.

Compensability

We affirm and adopt the Referee's order finding claimant's occupational disease claim for a right foot condition to be compensable.

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 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), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 18, 1992 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
**DAVID O. SHATTUCK, Claimant**
WCB Case Nos. 91-08884 & 91-04046
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Crawford and Company requests review of Referee Galton's order that: (1) set aside its denial of compensability and responsibility for claimant's "new injury" claim for a low back condition, including requested surgery; (2) upheld Aetna Insurance Company's responsibility denial for the same condition; and (3) required Crawford to provide the surgery for which authorization had been requested. On review, the issues are compensability, responsibility, and the reasonableness and necessity of surgery. We affirm in part and vacate in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact through the last paragraph on page 2 and supplement as follows.

In addition to Dr. Berkeley, claimant has treated with Drs. Smith, Schwartz, Twombly and Corrigan for his low back.

Claimant had a laminectomy and discectomy at L3-4 and L4-5 in 1957.

Claimant injured his right shoulder on May 24, 1990, while Crawford was on the risk. (Ex. 25).

On February 28, 1991, Crawford partially denied compensability of claimant's current low back condition on the basis that it was due to a preexisting degenerative disk disease condition. (Ex. 42; Tr. 13). On May 21, 1991, Crawford denied responsibility for the same condition on the basis that claimant's condition was an aggravation of his earlier industrial injuries when Aetna was on the risk. (Ex. 47).

On July 3, 1991, Aetna denied responsibility for claimant's condition. (Ex. 50) Because Crawford denied compensability, an order designating a paying agent under ORS 656.307 did not issue.

At hearing, the parties agreed that the reasonableness and necessity of surgery was not at issue. (Tr. 24 through 26).

## FINDINGS OF ULTIMATE FACT

We adopt the Referee's findings of ultimate fact, with the exception of his finding that curative surgery is required, reasonable and necessary, and we supplement as follows.

Claimant sustained a new low back injury in May 1990 when Crawford was on the risk, which required medical services. This injury is established by medical evidence supported by objective findings.

Claimant's new back injury involved the same low back condition as his 1985 low back injury when Aetna was on the risk.

## CONCLUSIONS OF LAW AND OPINION

Because the hearing was convened after July 1, 1990, this claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee concluded that claimant experienced a new compensable injury in May 1990, when Crawford was on the risk, involving the same low back condition as the November 1985 injury, when Aetna was on the risk. He consequently found that Crawford was responsible for claimant's current low back condition. See ORS 656.308.

Crawford contends that claimant did not sustain a new low back injury on May 24, 1990. Alternatively, Crawford contends that if claimant did sustain a low back injury on that date, he must prove that the new injury is the major contributing cause of his current disability or need for treatment, because he had a preexisting condition. Crawford also argues that the reasonableness and necessity of the requested surgery was not before the Referee.

Compensability

We first address Crawford's argument that claimant has a "preexisting condition" within the meaning of ORS 656.005(7)(a)(B). The Court of Appeals has recently held that ORS 656.005(7)(a)(B) defines what is compensable when a work-related injury combines with a preexisting noncompensable disease or condition to cause or prolong disability or a need for treatment. SAIF v. Drews, 117 Or App 596 (1993). Here, we do not find that claimant has a preexisting noncompensable disease or condition.

In 1957, claimant had a noncompensable laminectomy and diskectomy at L4-5 and L5-S1. Claimant began working as a truck driver for the self-insured employer on March 10, 1971. (Tr. 28). On November 19, 1985, claimant experienced a compensable low back injury when Aetna was on the risk. This injury resulted in an L4-5 herniated disc on the right, for which a laminectomy and diskectomy were performed. (Ex. 16). Aetna accepted the low back claim, and there is no evidence that Aetna denied any portion of claimant's condition on the basis that it was a "preexisting" noncompensable condition. Therefore, we do not find that claimant's low back condition prior to the May 24, 1990 was a preexisting condition within the meaning of ORS 656.005(7)(a)(B). Accordingly, claimant need not prove causation under a major contributing cause standard.

Responsibility

Aetna, as the last carrier against whom claimant had an accepted low back injury, is presumptively responsible for further medical services and disability relating to the compensable condition, unless claimant sustained an actual, independent compensable injury involving the same condition. See ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678 (1991). If we conclude that claimant sustained such an injury while Crawford was on the risk, all further compensable medical services and disability involving the same condition must be processed as a new injury claim by Crawford. See id.

We now turn to the relevant facts and medical evidence. On July 26, 1986, about six weeks after he returned to work following the compensable disc surgery, claimant fell off his truck and fractured his right ribs and injured his right shoulder and neck, requiring cervical surgery. Sometime after that surgery, claimant began to have an increase in right leg pain and numbness in his right heel; he sought no medical attention for these symptoms.

In September 1989, Crawford became the processing agent for the employer. (Ex. 52-5). Thereafter, on May 24, 1990, claimant fell off his truck again, injuring his right shoulder and hip. When claimant sought treatment for his shoulder from Dr. Twombly, he brought up his persistent, slowly progressing heel numbness and the loss of his Achilles reflex over the past two or three years. Twombly referred him to Dr. Corrigan, orthopedist, who diagnosed residuals related to claimant's prior surgeries. In October 1990, Dr. Berkeley, who performed a neurosurgical consultation, diagnosed advancing spondylotic changes in the lumbar spine with some radicular symptoms that required only occasional symptomatic treatment. (Ex. 33).

Claimant continued to work and his low back symptoms continued to worsen. On December 13, 1990, claimant returned to Dr. Twombly, reporting that his low back had become significantly worse, with severe low back pain on the right, radiating into the lateral thigh, anterior lateral shin, and top of the foot. Dr. Twombly diagnosed an acute exacerbation of right-sided sciatica. He opined that there was no direct relationship between the May 1990 injury and claimant's severe pain because of the length of time between the injury and claimant's current symptoms. He further opined that the exacerbation was related to claimant's previous back injuries and surgeries. (Ex. 36).

On December 17, 1990, claimant consulted Dr. Berkeley, who took him off work. He noted that claimant had always had some residual symptoms that fluctuated, but were never as severe as now. (Ex. 37). Based on a December 23, 1990 MRI, Dr. Berkeley found degenerative changes from L3 to S1, a protruded disc at L4-5 impinging on the nerve root, foraminal stenosis and lateral recess stenosis at L4-5, and foraminal stenosis and a disc bulge at L5-S1 on the right impinging on the S1 nerve root. He requested authorization for decompression surgery at L4-5 and L5-S1. (Exs. 39, 44 and 53).

Dr. Berkeley opined that the 1990 injury was the major contributing cause of claimant's current condition, disability and need for treatment, because, although claimant's degenerative changes at L4-5 and L5-S1 predated the 1990 injury, the symptoms at those levels had become increasingly severe after the injury. He also opined that the November 19, 1985 injury was not the cause of these severe symptoms. (Ex. 48). In addition, he supported his opinion by the history of the development of claimant's condition and the new findings since 1985. (Ex. 53).

Dr. Corrigan examined claimant only once, on July 31, 1990, well before claimant's condition progressed to the point where he could not work and the L4-5 and L5-S1 discs were diagnosed. At that point, Corrigan opined that claimant's condition was due to postoperative residuals. (Ex. 31-3).

Dr. Fuller, who performed a records review only, diagnosed claimant with preexisting, multi-level, degenerative disc disease, with a possible herniation at L4-5 secondary to the 1990 injury. (Ex. 41). He later expanded on this report, opining that the major cause of claimant's current low back condition was his "preexisting" back condition with the natural progression of bone spurs and scar tissue. At the same time, he opined that the May 24, 1990 injury may have provided some "waxing and waning" of the condition, but that there had been no new pathological findings over the past five years. (Ex. 52). Fuller's findings are belied by the greatly increased symptoms and new herniated disc findings identified by Dr. Berkeley. Dr. Twombly, who was also unaware of Berkeley's findings, opined that the sciatica he diagnosed was unrelated to claimant's 1990 injury. (Ex. 36).

Inasmuch as we do not find that claimant has a preexisting condition within the meaning of ORS 656.005(7)(a)(B), in order to prove a new compensable injury, Aetna must show that the May 24, 1990 injury was a material contributing cause of disability or the need for treatment. See SAIF v. Drews, supra; Mark N. Wiedle, 43 Van Natta 855 (1991).

We, like the Referee, are most persuaded by the opinion of Dr. Berkeley, because it is based on claimant's history of increasing symptoms on the right and new low back findings that differ from those noted by the other physicians, and because Berkeley had been treating claimant since 1981.

We find that Aetna has carried its burden of proving that the May 24, 1990 injury was a material contributing cause of claimant's subsequent disability and need for treatment. Accordingly, We conclude that Crawford is responsible for further disability and treatment relating to the low back condition.

Reasonableness and Necessity of Surgery

We vacate that portion of the order which required Crawford to pay for Dr. Berkeley's proposed surgery for two reasons. First, the parties agreed that they had not raised the issue of the reasonableness and necessity of surgery. See tr. at 13, 14 and 26. Second, even if they had, that issue is under the sole jurisdiction of the Director. See Stanley Meyers, 43 Van Natta 2643 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over Crawford'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 $1,500, to be paid by Crawford. 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 October 14, 1991, is affirmed in part and vacated in part. That portion of the order which required Crawford and Company to provide surgery is vacated. The remainder of the order is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by Crawford.

In the Matter of the Compensation of
**GREGORY A. WILSON, Claimant**
WCB Case Nos. 91-03406 & 90-19860
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

The Port of Portland (Port), a self-insured employer, requests review of Referee Hoguet's order that: (1) set aside its denial of claimant's occupational disease claim for a hearing loss condition; and (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of Schnitzer Steel Co. (Schnitzer), for the same condition. Claimant also requests review as to the Port and cross-requests review as to Liberty Northwest on the responsibility issue and to preserve claimant's rights against both employers. On review, the issue is responsibility. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last sentence of the last paragraph on page 3.

## FINDINGS OF ULTIMATE FACT

Claimant's work activities with Schnitzer are the cause of claimant's hearing loss.

Claimant's work activities with the Port did not contribute to his hearing loss condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee, applying the last injurious exposure rule, concluded that, because claimant's employment at the Port could have contributed to his bilateral hearing loss, the Port was responsible for the claim. He also concluded, based on Mr. Fairchild's report, that claimant's employment at the Port did contribute to claimant's condition. We disagree.

Claimant worked full time at Schnitzer from March 1966 through March 1981 and intermittently thereafter until he resigned in October 1985. During the last eight or ten years, he worked as a diesel crane operator. An April 1985 baseline audiogram administered by Schnitzer revealed that claimant had a hearing loss. Beginning in November 1986, during his employment at the Port, claimant was administered audiometric hearing tests on a regular basis. At the Port, claimant worked as a shift foreman directing a crew, worked in his office, or in the repair yard as a trouble shooter. Occasionally, he operated a crane. As a result of his hearing loss, claimant missed no work and sought no medical treatment.

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which has not been previously accepted. See Fred A. Nutter, 44 Van Natta 854 (1992). When, as here, a worker is not disabled by the occupational disease, the triggering event for assigning responsibility is the time when the worker first seeks medical treatment for the condition. Progress Quarries v. Vandering, 80 Or App 160, 163 (1986). We treat Dr. Lipman's examination on December 18, 1990 to evaluate claimant's hearing loss as the triggering event for the onset of disability.

If a worker's disability results from exposure to potentially causal conditions and the onset of disability is during a later employment, the last injurious exposure rule assigns responsibility to the last employer whose work could have contributed to claimant's disability. Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984); Inkley v. Forest Fiber Products Company, 288 Or 337, 345 (1980). Nevertheless, any employer against whom a claim is made can avoid responsibility by presenting evidence to prove that the cause of the worker's disability is another employment, a cause unrelated to the employment, or that the disability is not related to a work exposure in its employment. Boise Cascade Corp. v. Starbuck, supra; Bracke v. Baza'r, 293 Or 239 (1982); Castle & Cooke v. Alcantar, 112 Or App 392 (1992).

Here, the Port contends that claimant's hearing loss is not related to a work exposure in its employment because there is no persuasive medical evidence that claimant's work at the Port contributed to his hearing loss and because there is no evidence that claimant was exposed to injurious noise levels during his work there.

The causation of claimant's hearing loss is a complex medical question which must be resolved by expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967).

We are more persuaded by the well-reasoned opinion of Dr. Lipman, who tested claimant's hearing and had an accurate understanding of the difference in noise exposure between Schnitzer and the Port, an understanding which is supported by the Marine & Environmental Testing Inc.'s October 1991 noise survey. This survey was taken to evaluate the noise to which the Port's crane operators were exposed. The survey reported that crane operators work in a clean, quiet environment. The cranes are operated by electric motors and the cabs are enclosed. The crane operators' noise exposure is well below the recommended allowable level of 85 dBA. Dr. Lipman, who also had available a memorandum from Schnitzer outlining claimant's work history, opined that claimant's bilateral hearing loss is the direct result of loud noise exposure in his work as a crane operator at Schnitzer and that his employment at the Port did not contribute to it. He also based his conclusion on the six audiograms taken since April 1985, which indicated that claimant had no appreciable hearing loss due to exposure at the Port, i.e., no increase greater than five decibels at any frequency and minor changes that are accepted deviations caused by testing variations.

Mr. Fairchild, audiologist, based his opinion on the cause of claimant's hearing loss on a review of the history and exhibits as supplied by Schnitzer. He did not examine claimant, visit claimant's place of work, and did not conduct any noise surveys. In addition, Mr. Fairchild discounted claimant's own evaluation that his job at the Port was less noisy as unreliable because of claimant's hearing loss. We are not persuaded by this assumption, based on claimant's testimony that the daily noise level at Schnitzer was ten times worse than at the Port. This testimony indicates to us that claimant was able to discern a considerable difference in work place noise despite his hearing loss. Furthermore, Mr. Fairchild failed to use the presbycusis factor to calculate the percentage hearing loss, as required by the Oregon Administrative Rules, to determine "true hearing loss."

In addition to his reliance on Mr. Fairchild's report, the Referee identified sandblasting and steam venting noises as potentially harmful noises which enabled him to conclude, independently of the medical evidence, that noise at the Port could have contributed to claimant's hearing loss.

Whether or not an exposure is injurious at claimant's place of employment is a complex medical question for the medical experts to decide. See Roy I. Cannon, 42 Van Natta 1733, 1744 (1990). Here, there is no medical evidence that the occasional steam venting and sandblasting were injurious. In addition, the survey evidence took into account exposures to occasional loud noises from steam venting and sandblasting. It concluded that the crane operators at the Port were exposed to noise well below the allowable exposure level and that, even if exposures were doubled, exposures would still be less than the 85 dBA level.

We conclude that the Port has proven that the cause of the worker's disability is another employment and that claimant's disability is not related to a work exposure in its employment. See Boise Cascade Corp. v. Starbuck, supra; Bracke v. Baza'r, supra; Castle & Cooke v. Alcantar, supra. Accordingly, we conclude that Schnitzer is responsible for claimant's hearing loss claim..

Claimant is entitled to an assessed attorney fee under ORS 656.382(2) for services 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 attorney's services on review is $500, 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.

## ORDER

The Referee's order dated November 7, 1991 is reversed. The Port of Portland's denial is reinstated and upheld. Liberty Northwest Insurance Corporation's denial, on behalf of Schnitzer Steel, is set aside and the claim is remanded to Liberty Northwest for processing according to law. The Referee's attorney fee award shall be paid by Liberty Northwest, rather than the Port of Portland. Claimant's attorney is awarded $500 for services on Board review, to be paid by Liberty Northwest.

In the Matter of the Compensation of
**RICHARD N. WIGERT, Claimant**
WCB Case No. 91-08452
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Claimant requests reconsideration of our January 21, 1993 order which: (1) declined to award temporary total disability benefits after December 13, 1990; (2) assessed a penalty for an unreasonable failure to close the claim; and (3) found that the insurer had not unreasonably resisted the payment of a diagnostic test. Asserting that a compensability issue which is presently pending before the Hearings Division may have a substantial impact on some of the issues in this case, claimant seeks an indefinite abatement of our order to await resolution of that compensability issue.

In order to further consider claimant's motion, we withdraw our January 21, 1993 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ADAM H. BERKEY, Claimant**
WCB Case No. 90-19924
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney
D. Kevin Carlson, Assistant Attorney General

Reviewed by Board Members Gunn and Westerband.

The alleged noncomplying employer, Noah Berkey, and the Department of Insurance and Finance (Department) request review of Referee Garaventa's order that: (1) set aside the SAIF Corporation's denial of claimant's injury claim purportedly on behalf of Noah Berkey; (2) assessed a penalty and related attorney fee against SAIF for an allegedly unreasonable denial; and (3) awarded an $18,500 assessed attorney fee. In its brief, the Department contends that the record was improperly developed because it had no opportunity to examine or object to the testimony of principal witnesses. On review, the issues are remand, subjectivity, penalties and attorney fees. We deny the motion to remand and affirm in part and reverse in part.

FINDINGS OF FACT

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

The Department issued an order declaring Noah Berkey a noncomplying employer on October 5, 1990. (Ex. A-4). The Department subsequently received additional information from Noah Berkey concerning his employment arrangement with claimant which caused the Department to rescind its noncompliance order on October 17, 1990. (Ex. 11). Thereafter, on October 17, 1990, the Department referred the case to SAIF under former OAR 436-80-060(2), with instructions to deny the claim on the basis that claimant was not a subject employee of Noah Berkey on the date of injury. (Ex. 2). On the same day, in accordance with the Department's instructions, SAIF denied the claim. (Ex. 3).

Claimant requested a hearing on the denial. SAIF waived appearance at the hearing. (Ex. 13). However, the Department was represented at the hearing by its attorney. At the hearing, claimant's attorney objected to the Department's participation on the basis that SAIF, not the Department, was the real party in interest. The Referee initially overruled the objection, but pursuant to an April 5, 1991 interim order, referred the case to the Department for reissuance of an order of noncompliance. The Referee reasoned that SAIF's denial had been issued under ORS 656.054 in response to the subsequently rescinded noncompliance order.

Claimant formally requested a hearing on a "de facto" denial by the alleged employer. A motion to incorporate the entire record was granted.

Over its objection, the Department was dismissed as a party at the continued hearing on May 13, 1991. Claimant's testimony was taken that day. Because of its dismissal, the Department's attorney was not present for claimant's testimony and did not have the opportunity to conduct cross-examination. Also, while the Department remained dismissed from the proceeding, the telephone deposition of Clifton Berkey (Noah Berkey's son and claimant's brother) was taken on May 24, 1991, before the Referee. The Department's attorney was allowed to question Clifton Berkey in an offer of proof outside the Referee's presence, but was not allowed by the Referee to make objections.

On June 7, 1991, the Department moved for reconsideration of the Referee's dismissal ruling. Claimant responded to the Department's motion arguing, among other things, that all parties of interest including the Department were present and participated in the hearing so that the Referee could issue a final order. In a June 14, 1991, letter to the Referee, the Department replied:

> "DIF did not have an opportunity to participate fully in any proceedings subsequent to its dismissal. However, it is content to stand on the factual record developed prior to that time as a basis for the referee's ruling. That record clearly requires the referee to issue a final order that affirms SAIF's denial and dismisses with prejudice the hearing requested by claimant's guardian." (Emphasis added).

In her Opinion and Order, the Referee granted the Department's motion for reconsideration, determining that her prior ruling was based on the mistaken understanding that the posture of the case remained under ORS 656.054 rather than under former OAR 436-80-060(2). The Referee, therefore, withdrew her interim order referring the case to the Department for reissuance of an Order of Noncompliance and her ruling dismissing the Department as a party.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was an Oregon subject worker temporarily working in California incidental to his employment for Noah Berkey, the alleged noncomplying employer. Both Noah Berkey and the Department have requested review of that decision. Noah Berkey contests the Referee's conclusion that claimant was an Oregon subject worker and that Noah Berkey was an Oregon subject employer.

### Remand

As previously noted, as a result of the Referee's decision to dismiss it from participating in the hearing, the Department was not present during claimant's testimony and did not have the opportunity to cross-examine claimant. The Department argues that it was not allowed to object to the testimony of Clifton Berkey, and was only allowed to question Clifton Berkey in an offer of proof outside the Referee's presence. We interpret the Department's arguments concerning the record as a motion for remand.

We may remand a case to the Referee for further evidence taking 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).

Because claimant may be found to be an Oregon subject worker as a result of this proceeding, we agree with the Referee's conclusion that the Department is a party in interest. The Department has a "stake in the outcome" of this matter because, should Noah Berkey be determined to be a subject employer, the Department will be responsible for reimbursing SAIF's claims processing costs and for recovering those costs from the alleged noncomplying employer. ORS 656.054(3). Thus, the Department has an interest in this proceeding which has been recognized by the legislature. See Trojan Concrete v. Tallant, 107 Or App 429 (1991).

As a party in interest, the Department was entitled to be present when claimant testified and was entitled to conduct cross-examination. In addition, it was entitled to object to Clifton Berkey's

deposition testimony and conduct its cross-examination in the presence of the Referee. However, in seeking reconsideration of the Referee's dismissal ruling, the Department did not advance its objections to these evidentiary rulings. In fact, the Department essentially waived any such objection by stating that it was "content to stand on the factual record developed" prior to its exclusion as a basis for the Referee's final order.

Having failed to preserve its objection to submission of Clifton Berkey's deposition and claimant's testimony, we conclude that the Department is precluded from now raising that objection on review. Marty L. Hornback, 44 Van Natta 975 (1992); Joseph B. Beaulieu, 40 Van Natta 1199 (1988). Accordingly, since we consider the record sufficiently developed and because we find no compelling reason to remand, we deny the Department's motion.

Subjectivity

We adopt the conclusions and reasoning of the Referee concerning the subjectivity issue with the following supplementation.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or 186 (1992).

Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. We have previously held that in order for the out-of-state work to be "incidental" to work performed in Oregon for an Oregon employer under ORS 656.126(1), there must be proof of an established employment relationship between the worker and his Oregon employer before the out-of-state injury occurs. Steven A. Dancer, 40 Van Natta 1750 (1988); Daryl W. Hugulet, 37 Van Natta 1518 (1985). Proof of such a relationship is established if the worker has a reasonable expectation of returning to work for the employer in Oregon. Roy L. Center, 44 Van Natta 365 (1992); Lyle E. Estes, 43 Van Natta 62 (1991).

Here, we conclude that claimant had a reasonable expectation of returning to work for Noah Berkey in Oregon after completing the California project. In this regard, Noah Berkey relied primarily on his sons, including claimant, to perform the labor required in his pole barn business. Further, when claimant briefly moved out of state after high school, he was told by Noah Berkey that he could return to Oregon and work for him. We find, based on the record as a whole, claimant had a reasonable expectation of returning to work for Noah Berkey in Oregon after the California job was completed. Thus, we agree with the Referee that claimant was a subject worker at the time of his injury.

Notwithstanding this conclusion, we find that the claim is not properly before SAIF for processing pursuant to ORS 656.054. We reach this conclusion because the Department has not issued an order finding Noah Berkey to be a noncomplying employer. At the time the Department referred the claim to SAIF, the Department had rescinded its noncompliance order. Rather than referring the claim to SAIF under ORS 656.054 by means of a noncompliance order, the Department referred the claim to SAIF pursuant to former OAR 436-80-060(2). That rule allowed the Department to refer a claim to SAIF in the absence of an Order of Noncompliance when the Department found either that the worker or the employer was not subject to the workers' compensation law. We have held that referral of a claim to SAIF for processing in the absence of an Order of Noncompliance is not statutorily authorized. Jerry M. Banks, 44 Van Natta 2561 (1992); see also James L. Guyton, 41 Van Natta 1277 (1989) (ORS 656.054 is the sole statutory authority for referring a noncomplying employer claim to SAIF for processing).

In Jerry M. Banks, supra, the Department was unable to determine whether the claimant was a subject worker and referred the claim to SAIF for processing under former OAR 436-80-060(2). Although the claim was referred to SAIF, no noncompliance order was issued by the Department. We held that since a noncompliance order had not issued, responsibility for processing the claim remained with the Department. Likewise, in the present case, responsibility for directing the processing of this claim remains with the Department. The claim may only be properly referred to SAIF for processing if the Department issues a noncompliance order.

Here, as in Banks, SAIF issued a compensability denial concerning claimant's claim acting under the color of its authority under former OAR 436-80-060(2). We conclude, therefore, as we did in Banks, that SAIF's denial raised a matter concerning a claim which required claimant to request a hearing to protect his rights. ORS 656.283(1); ORS 656.704(1). Thus, the Referee properly proceeded to determine the subjectivity issue. As was the case in Banks, the subjectivity issue has been fully litigated with all parties present. Therefore, our decision will likely have a preclusive effect on the Department's future decisions regarding the issuance of a noncompliance order and eventually SAIF's future processing of this claim.

Penalties

The Referee assessed a penalty against SAIF pursuant to ORS 656.262(10). In assessing a penalty, the Referee reasoned that the alleged employer's conduct constituted an attempt to avoid obtaining workers' compensation insurance, as well as workers' compensation liability.

The Department contends that the Referee's assessment of a penalty against SAIF pursuant to ORS 656.262(10) is inappropriate. We agree for the following reasons.

A penalty for unreasonable denial may be assessed against SAIF (as the statutory claim processor for a noncomplying employer) where the denial is issued as a result of unreasonable conduct by the noncomplying employer. See Anfilofieff v. SAIF, 52 Or App 127 (1981). However, we have earlier concluded that because no Order of Noncompliance had issued, the Department was without authority to refer this matter to SAIF. See ORS 656.054; Jerry M. Banks, supra. Since the claim had not been referred to SAIF under ORS 656.054, SAIF had no duty to process the claim. See, e.g., Eldon Burbank, 44 Van Natta 1250, 1252 (1992); Kenneth R. Derrick, 42 Van Natta 274 (1990). (No duty to process a noncomplying employer claim until the Director has referred the claim to SAIF pursuant to ORS 656.054). Thus, a penalty is not warranted.

Furthermore, ORS 656.262(10)(a) allows a penalty to be assessed against an insurer or self-insured employer for unreasonable delay or refusal to pay compensation. Here, in part, the Referee assessed a penalty against SAIF based on the alleged noncomplying employer's failure to obtain workers' compensation insurance. Civil penalties are assessed against noncomplying employers under ORS 656.735 by the Director for such conduct. Accordingly, we decline to assess penalties for the same conduct under ORS 656.262(10).

Finally, even if SAIF had a duty to process the claim for Noah Berkey, we conclude that the "subjectivity" denial was not unreasonable. The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). The standard for determining whether a denial is unreasonable is whether a legitimate doubt existed as to its liability for the claim. Id.

Here, following a Department investigation, it was determined that claimant was not an Oregon subject worker when he was injured. Based on existing statutory and case precedent, there was reason to believe that claimant did not have a reasonable expectation for further employment in Oregon once the California job was completed. Although that belief has since been dispelled, we conclude that SAIF had a legitimate doubt as to the employer's liability at the time of the denial. See, e.g., Roy L. Center, supra. Accordingly, a penalty is not appropriate.

Attorney Fee/Hearing Level

The Department contends that the Referee awarded an excessive attorney fee. 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 attorney's services at hearing is $18,500, 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 statement of services), the complexity of the issues, and the value of the interest involved.

Attorney Fee Board Level

Claimant is entitled to an assessed attorney fee for services on Board 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 is $1,500, to be paid by the SAIF Corporation on behalf of the Department and the alleged 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 issues, and the value of the interest involved. In determining a reasonable fee, we have noted that 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 July 12, 1991 is reversed in part, affirmed in part and modified in part. That portion of the Referee's order which assessed a penalty against SAIF is reversed. Responsibility for the further processing of this claim currently rests with the Compliance Section, which will determine whether the issuance of an order finding Noah Berkey to be a noncomplying employer under ORS 656.054 is warranted. For services on review, claimant's attorney is awarded $1,500 payable by SAIF. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**JANICE S. BROWN, Claimant**
WCB Case No. 91-07341
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant requested reconsideration of our October 15, 1992 Order on Review. Pursuant to that request, we abated our order to allow the insurer an opportunity to respond. The insurer's response has been received.

Our original order affirmed the Referee's conclusion that claimant had not established a new compensable injury or occupational disease. Claimant contends that the Referee's conclusion that claimant had not established a new compensable injury is in error, because he based his conclusion on the theory that the medical evidence did not present "objective evidence" of new pathology. We disagree.

The Referee also stated:

> "Even assuming that Dr. Golden's reports are interpreted as indicating objective findings, given claimant's long history of ongoing low back problems and the fact that she sought treatment from Dr. Golden for increased symptoms immediately prior to the alleged injury incident, the preponderance of evidence does not indicate that any incident which occurred on April 4, 1991, was a material cause of claimant's need for medical treatment in late April 1991 and thereafter. Rather, claimant's need for medical treatment and disability in late April 1991 was simply a continuation of the residuals of her 1982 industrial injury."

This conclusion is supported by the reports of Drs. Becker and Baker, who independently concluded that claimant's symptoms were not new, but a continuation of the symptoms she had experienced since 1982.

For these reasons, we find that claimant has not established that the alleged April 4, 1991 incident was a material contributing cause of her disability or need for treatment.

Accordingly, as supplemented herein, we adhere to and republish our October 15, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARY DAVENPORT, Claimant**
WCB Case No. 91-17618
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Garaventa's order that set aside its denial of claimant's claim for a right knee condition. In its brief, SAIF contends that claimant is precluded from arguing that her current right knee condition is causally related to a February 1991 work injury, because no claim for that incident was timely filed. 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's right knee condition was compensable. We agree.

### February 1991 Injury Claim/Timeliness Defense

In determining that claimant's right knee condition was compensable, the Referee found that in addition to the claimed October 4, 1991 injury, claimant had sustained a prior work injury to the right knee in February 1991. The Referee concluded, based on the medical evidence, that the February 1991 incident caused an initial tear of the medial meniscus of the right knee and that the October 1991 incident ruptured the tear. Claimant contended at hearing that her right knee condition was caused by the February 1991 work injury as well as the October 1991 injury. Claimant testified she did not timely file a workers' compensation claim for the February 1991 injury because she feared losing her job.

An initial question, not specifically raised by the parties or addressed by the Referee, is whether a claim was ever filed for the February 1991 injury.

A "claim" is a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. ORS 656.005(6). 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). We conclude that Dr. Henshaw's reports, which request medical services for the effects of both the February 1991 incident and the October 4, 1991 injury, constitute a claim for the February 1991 injury.

We note that the record does not support a finding that the employer had actual knowledge of the February 1991 injury when it occurred. The February 1991 injury was unwitnessed and, although claimant told her supervisor that she had hurt her knee, she did not stress that the knee condition was related to work, did not seek medical treatment or ask to file a claim. The employer was aware of a knee condition after February 1991, but was under the impression that it was due to arthritis unrelated to work.

Since we have concluded that a claim was filed for the February 1991 injury, we proceed to address SAIF's timeliness defense. On review, SAIF contends that a claim for the February 1991 incident is barred as untimely under ORS 656.265. SAIF was aware at hearing (and via Dr. Henshaw's reports) that claimant was contending that a February 1991 work injury as well as the October 1991 injury contributed to her knee condition. However, SAIF did not raise its timeliness defense to the claim at hearing. ORS 656.265(5) requires that the issue of failure to give notice of an injury must be raised at the first hearing on a claim for compensation in respect to the injury or death. See also Wilson

v. Roseburg Forest Products, 113 Or App 670, 673 (1992); Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board will not consider issues not raised before the Referee); Leslie Thomas, 44 Van Natta 200 (1992) (issue of untimely claim filing not properly raised when first asserted during closing arguments). Inasmuch as SAIF failed to raise the timeliness issue at hearing, that defense is waived.

Credibility/Compensability

We adopt the reasoning and conclusions of the Referee with the following supplementation.

The Referee found that claimant was not candid regarding several of her statements to the employer and noted that there were discrepancies between claimant's testimony and that of other witnesses. However, the Referee concluded that the record supported claimant's contention that she was injured at work in February 1991, as well as October 1991. We agree.

Claimant's testimony regarding an injury in February is consistent with the findings of Drs. Henshaw and Woolpert on examination. Dr. Henshaw noted that there was evidence of recent trauma to the knee as well as degenerative chondromalacia which was consistent with claimant's reports of a February 1991 injury. Dr. Woolpert stated that the type of mechanism described by claimant could cause a torn meniscus. He also felt that the October 1991 incident involved a completion of a preexisting tear. Furthermore, there was no evidence presented that would suggest that an off work injury or activity was responsible for the knee condition. Accordingly, we conclude that the record supports a finding that claimant suffered a right knee injury at work in February 1991. See Taylor v. Multnomah School Dist. No. 1, 109 Or App 499 (1991).

Having concluded that a February 1991 injury did occur, we turn to compensability of the right knee condition. Claimant has the burden to prove that the February and October 1991 injuries are a material contributing cause of her disability and need for treatment. ORS 656.266; Mark N. Weidle, 43 Van Natta 855 (1991).

Here, claimant's treating physician, Dr. Henshaw, opined that the February 1991, injury resulted in a bucket handle tear of the meniscus and the October 1991 injury ruptured the tear. Dr. Henshaw also opined that by walking on the torn meniscus for eight months, claimant developed degenerative chondromalacia of the medial compartment. Dr. Henshaw felt that the February and October injuries were the major contributing cause of claimant's right knee condition. Dr. Woolpert saw claimant for an independent medical examination. Dr. Woolpert felt that there was a preexisting injury to the knee prior to the October 1991 injury and that if a February 1991 work injury had occurred, then the major contributing cause of the right knee condition was that injury.

On the basis of this evidence, we conclude that claimant has established the compensability of her right knee condition.

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 March 20, 1992 is affirmed.

In the Matter of the Compensation of
**BUCK E. JOHNSON, Claimant**
WCB Case No. 91-15665
ORDER ON REVIEW
Max Rae, Claimant Attorney
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Westerband, Brazeau, and Gunn.

Claimant requests review of Referee Garaventa's order that denied his request for an adjustment in the calculation of permanent and total disability benefits. On review, the issue is offset and attorney fees. We affirm.

## FINDINGS OF FACT

Claimant sustained a compensable injury, for which he was awarded benefits for permanent and total disability (PTD). For legal services incurred in obtaining those benefits, claimant's attorney was awarded 25 percent of the compensation awarded, not to exceed $6,000. Consequently, claimant received monthly PTD benefits equalling $630.53, $157.63 of which was payable to his attorney.

In addition to receiving PTD benefits, claimant also received $620.60 in monthly federal Social Security benefits. Because claimant was receiving both PTD and Social Security benefits, the Workers' Compensation Division ordered the SAIF Corporation to reduce claimant's PTD benefits to $206.60 per month, so that claimant's combined benefit level would not exceed $827.20, or 80 percent of his average current earnings. Claimant subsequently requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

Claimant seeks review of the Referee's decision upholding the the Division's offset order reducing the amount of his monthly PTD benefits. Claimant acknowledges that ORS 656.209 authorizes the reduction of PTD benefits if an injured worker concurrently receives Social Security disability benefits. He argues that the Division computed the offset amount incorrectly, because it failed to consider the attorney fee payable from his gross monthly PTD benefits. We affirm.

ORS 656.209 provides, in part:

> "(1) With the authorization of the department, the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.
>
> "* * * * *
>
> "(b) If the benefit amount to which the worker is entitled pursuant to this chapter is less than the workers' federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in workers' compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount of combined benefits the worker receives below the federal benefit limitation."

In this case, claimant received monthly PTD benefits totalling $630.53. He also received monthly Social Security benefits totalling $620.60. Because his federal benefit limitation is $827.20 per month, the Referee concluded that the Division correctly ordered SAIF to reduce claimant's monthly PTD benefit to $206.60. ($206.60 PTD benefit + $620.60 Social Security benefit = $827.20 benefit limitation.) We agree.

On review, claimant argues that the above computation is in error, because it fails to consider the 25 percent attorney fee payable from his gross monthly PTD benefits. He argues that the attorney fee should be excluded from the offset procedure so that, in effect, he would receive the full $827.20 plus an additional amount for the attorney fee. He explains:

"The state may not apply the federal benefit limitation in a way that would reduce claimant's net checks below the limitation level that the federal government would have applied. Accordingly, so long as attorney fees are being taken out of permanent total disability benefits, those benefits must be increased sufficiently so that claimant's net share equals the $206.60 difference between the $620.60 social security payment and the $827.20 federal benefit limitation. In order to net claimant $206.60 after a 25 percent attorney fee, the permanent total disability benefit must be $275.46." App. brief at 6.

Claimant's argument is apparently based on the belief that the attorney fee is not a benefit to claimant. That is incorrect. Unlike an assessed fee, an out-of-compensation attorney fee is part of a claimant's compensation. Steiner v. E.J. Bartells Co., 114 Or App 22 (1992). Accordingly, that portion of the PTD award payable to claimant's attorney for services incurred in obtaining compensation is properly considered a benefit to claimant.

Claimant also argues that the attorney fee must be excluded under ORS 656.209 to parallel the federal regulations governing the offset of state benefits against social security benefits in those states that have not enacted their own statutes reversing the offset process. See 20 C.F.R. § 404.408(d). We are not persuaded by that argument. While such an exemption is available under the federal offset procedure, there is no similar provision under Oregon law. Moreover, the federal and state benefit reduction schemes are distinct creatures and, while the results reached under ORS 656.209 may differ from those obtained under federal law, we find no Congressional intent that the federal method of reduction preempt the various state reduction statutes. See generally Robert L. Reed, et al, 42 Van Natta 1907 (1990).

After our review, we conclude that the 25 percent out-of-compensation fee is properly considered as a benefit to claimant. Accordingly, the Division properly included the attorney fee in the offset determination, and correctly ordered SAIF to reduce claimant's monthly PTD benefit to $206.60, so that claimant receives a combined benefit amount equal to the federal disability benefit limitation.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

**Board Member Gunn dissenting:**

The majority concludes that an out-of-compensation attorney, granted in connection with a permanent total disability award, is "compensation" for purposes of offsetting social security disability benefits. Because I believe that this result conflicts with federal statutes, I dissent.

At the outset, I acknowledge that, for purposes of Oregon's workers' compensation law, out-of-compensation attorney fees are considered part of claimant's compensation. See Steiner v. E.J. Bartells Co., 114 Or App 22 (1992). However, the situation here does not involve only benefits payable under the state workers' compensation law. Rather, it also involves social security benefits payable under federal statutes. Therefore, I do not believe that the decision in Steiner, supra controls the outcome of this dispute.

ORS 656.209 provides in relevant part:

"(1) With the authorization of the department, the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.

"(b) If the benefits amount to which the worker is entitled pursuant to this chapter is less than the worker's federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount of combined benefits the worker receives below the federal benefits limitation." (Emphasis supplied).

The emphasized portion of the statute clearly indicates that benefit limitations is to be determined by federal law. The federal law referenced by the statute provides that legal expenses incurred in connection with a claim for public disability payments or the injury or occupational disease on which the public disability award is based are excluded in computing the offset of federal benefits. 20 CFR § 404.408(5)(d).

Since ORS 656.209(1)(b) contemplates that offsets against social security disability benefits will be governed by federal law and the relevant federal law excludes attorney fees as amounts that will be offset against social security benefits, the majority's reliance upon Steiner, supra is misplaced. While Steiner, supra may represent the general law with regard to attorney fees being "compensation," ORS 656.209(1)(b), when read in conjunction with the relevant federal provisions, provides a specific exception. Therefore, I would not consider claimant's out-of-compensation attorney fee as "compensation" in this instance.

The majority's reading of ORS 656.209 not only contravenes federal law, it also results in a reduction of benefits to this claimant. For these reasons, I respectfully dissent.

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In the Matter of the Compensation of
**VADOR RUTH KENNEDY, Claimant**
WCB Case No. 90-06671
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The insurer requests review of that portion of Referee Black's order which set aside its denial of claimant's aggravation claim for a psychiatric condition allegedly related to an accepted injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, who was 58 years old at the time of the hearing, fell on stairs at work on June 8, 1988, bruising her right knee and right arm and straining her neck and lower back. (Exs. 43, 45, 46). The insurer accepted a nondisabling injury on July 8, 1988. (Ex. 47). Claimant was treated beginning in June 1988 by Dr. Larson, M.D., for right knee pain. (Ex. 20-15).

Claimant came under the care of Dr. Watrous, orthopedist, on May 1, 1989. (Exs. 51, 52-1). On June 16, 1989, Dr. Watrous took claimant off work due to her knee condition, and the insurer subsequently accepted her right knee aggravation claim as disabling. (Exs. 52-3, 56).

On November 2, 1989, Dr. Watrous performed surgery to treat a neuroma and inflammation of the infrapatellar fat pad of the right knee. (Ex. 58). In February 1990, Dr. Watrous declared claimant to be medically stationary, but unable to return to her regular work as a security guard. He released claimant to return to primarily sedentary work, with restrictions on standing, walking, and going up and down stairs. (Exs. 61, 63). A Determination Order issued March 16, 1990, awarding 9 percent scheduled permanent disability for the right knee. (Ex. 65).

In April 1990, claimant began treating with psychologist Dr. Naffzinger, Ph.D., on referral from Dr. Larson. (Exs. 74, 78). Dr. Naffzinger observed that claimant was extremely depressed, in considerable pain, and anxious about her vocational future. (Exs. 74, 80). Claimant was treated with antidepressant medication, as well as counseling with Dr. Naffzinger. (See Exs. 73-2, 85A).

Claimant underwent an independent psychiatric examination on September 12, 1990 by Dr. Holland, psychiatrist. (See Ex. 89). Dr. Holland diagnosed Somatoform Pain Disorder and Dysthymia, secondary to the pain disorder, as well as Dependent Personality Disorder with histrionic traits. (Ex. 89-

23 to -24). He opined that claimant's principal psychiatric diagnosis, dependent personality disorder, preexisted the June 8, 1988 injury, and he hypothesized that claimant probably has had chronic depression which has presented through somatization. (Ex. 89-26). After reviewing prior medical reports, Dr. Holland concluded there is evidence back to 1969 of psychological factors significantly contributing to claimant's pain complaints. (Ex. 95-4).

Claimant's husband of 41 years has been disabled for approximately 30 years and receives both workers' compensation and social security disability benefits. (Tr. 14, 17; Ex. 89-18).

In December 1982, while employed as a security guard in the Eugene/Springfield area, claimant fell at work, sustaining a cervical injury that required surgical treatment in February 1983, July 1984, and June 1985. (Exs. 5, 8, 22, 29). Following the first surgery, an independent examiner noted mild functional interference manifested by depression and anxiety stemming from claimant's fear of losing her job at that time. (Ex. 11A-3). Following the cervical fusion performed by Dr. Smith, claimant was able to resume work as before and no longer felt depressed. (Tr. 10, 26).

Claimant had been prescribed antidepressant medications prior to June 1990, but she had never sought psychological treatment before treating with Dr. Naffzinger. (See Exs. 19, 20-13 to 20-15, 89-13).

## CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's current psychological condition, which resulted in disability and required treatment beginning in April 1990, to be compensable. He analyzed this claim under ORS 656.005(7)(a)(B) because he found that claimant had a preexisting psychological condition which combined with her compensable injury. He concluded that the compensable work injury of June 1988, which resulted in a knee injury and subsequent surgery and job loss, was the major contributing cause of a worsening of claimant's preexisting psychiatric condition, which required treatment and resulted in disability. Accordingly, the Referee found claimant's current psychological condition to be compensable.

We agree with the Referee's conclusion that claimant's current psychological condition is compensable, but we do so based on the following reasoning.

We analyze this case under subsection (A) of ORS 656.005(7)(a), rather than subsection (B). When a condition or need for treatment is caused by a compensable injury, as distinguished from being directly caused by the industrial accident, the "consequential condition" is compensable if the compensable injury is the major contributing cause of the consequential condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Here, claimant seeks compensation for a psychological condition which she contends arose as a consequence of her compensable right knee injury. Accordingly, we analyze this claim under ORS 656.005(7)(a)(A).

Although there is medical evidence in the record that claimant had a preexisting psychological condition, we find that ORS 656.005(7)(a)(B) is not applicable in this case. The Court of Appeals explained that under ORS 656.005(7)(a)(B), when a work-related injury has combined with a preexisting condition, the resultant condition is compensable only if the work-related injury is the major contributing cause of the resultant disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Here, compensability of the work-related injury is not at issue, since claimant's right knee condition has previously been found compensable. Instead, the issue is compensability of a psychological condition, which claimant alleges was caused by the compensable injury and its sequelae. Therefore, we conclude that this case is properly analyzed under ORS 656.005(7)(a)(A) as a secondarily consequential condition. Moreover, we note that under either subsection, claimant must prove that the compensable injury is the major contributing cause of her current psychological condition.

The issue of whether claimant's compensable injury, including subsequent surgery and job loss, is the major contributing cause of her consequential condition 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).

Dr. Naffzinger, claimant's treating psychologist, believes that claimant's current psychological condition "is related in major part to her industrial injury and its sequelae." (Ex. 80-1). Dr. Naffzinger

explains that claimant's "well being and her self image have been closely connected to her work life." (Ex. 80-1). Because she was unable to return to her regular work, claimant became depressed, tearful, and anxious about her vocational future. Dr. Naffzinger observed that claimant was "extremely depressed" and "totally devastated psychologically due to her industrial injury and her inability to work." (Exs. 80-1, 100).

Psychologist Dr. McConochie, Ph.D., examined claimant once for a social security disability evaluation. He diagnosed "major depression, single episode, moderate," but no personality disorder. (Ex. 82A-5). He noted that claimant seemed "considerably depressed and worried over her perceived inability to resume employment and related worries about loss of family income." (Id.). Dr. McConochie observed that worry about her inability to continue working appears to explain much of claimant's current depressed state. (Ex. 82A-3). He advised continued medical support and supportive counseling for claimant's depression. (Ex. 82A-5). Dr. Naffzinger agreed with Dr. McConochie's report. (Ex. 99).

Dr. Holland, psychiatrist, conducted an independent psychiatric examination in September 1990. (Ex. 89). He diagnosed claimant's condition as somatoform pain disorder with dysthymia secondary to the pain disorder; in addition, he diagnosed a dependent personality disorder with histrionic traits, which he regarded as the principal psychiatric diagnosis. (Ex. 89-23 to -24, 89-26). He believed that all three psychological conditions preexisted the compensable right knee injury. (Tr. 60).

We defer to Dr. Naffzinger's opinion, as supported by that of Dr. McConochie. As claimant's treating psychologist, Naffzinger was in the best position to evaluate claimant's current psychological condition.

Further, we note that although claimant used antidepressant medications prior to June 1990, when Dr. Watrous prescribed such medication, she never required psychological counseling before treating with Dr. Naffzinger, nor were her preexisting psychological conditions disabling until after her knee surgery in November 1989. (Tr. 78-79; Ex. 89-13). Thus, we find that the compensable 1988 injury and its sequelae, including subsequent surgery, disability, and loss of her regular job, precipitated, or caused, claimant's current disability and need for psychological treatment. We note that Dr. Holland agrees that claimant requires treatment for her current condition, but he recommends antidepressant medication and treatment in a pain center, rather than psychotherapy. (Tr. 71, 79).

We recognize that Dr. Holland also opined that the 1988 knee injury played no role in claimant's current psychological condition. (Tr. 55, 59). We note that Dr. Holland's focus was solely on the original 1988 injury, which was initially accepted as nondisabling. We do not find that Dr. Holland considered any subsequent developments in claimant's knee claim in making his statement. Thus, we are not persuaded by Dr. Holland's opinion that the knee injury played no role in claimant's current condition, since Dr. Holland failed to consider the sequelae of the original injury.

We find that the record as a whole establishes that the 1988 knee injury and its sequelae are the major contributing cause of claimant's current disability and need for psychological treatment. Accordingly, we affirm the Referee's determination that claimant's current psychological condition is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 $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 claimant's respondent's brief and the attorney's statement of services), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated September 17, 1991 is affirmed. Claimant's attorney is awarded $2,500 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
**DAVID F. MEISSNER, Claimant**
WCB Case No. 91-04509
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee Hazelett's order that set aside an order of the Director of the Department of Insurance and Finance concerning claimant's likely eligibility for vocational assistance. We modify.

## FINDINGS OF FACT

Claimant was working as a truck driver on June 1, 1983, when he slipped and fell while walking up a loading ramp, injuring his left leg and foot. The insurer accepted the claim and provided benefits.

On September 24, 1984, the Department issued a Determination Order, awarding benefits for temporary disability. By stipulated order dated November 6, 1984, claimant was awarded benefits for 10 percent scheduled permanent disability.

Claimant returned to regular work in October 1983, but soon thereafter began experiencing occasional left knee pain. He was examined in 1986 by Dr. Bald, an orthopedic surgeon, who diagnosed a torn medial meniscus related to the 1983 injury. Dr. Bald surgically removed the torn cartilage in October 1986, and declared claimant medically stationary in January 1987. On March 4, 1987, the Department issued a second Determination Order, awarding benefits for an additional 15 percent scheduled permanent partial disability.

In November 1989, claimant's knee condition worsened. He returned to Dr. Bald, who diagnosed an anterior cruciate deficiency and recommended surgery. The insurer accepted responsibility for the condition and, because claimant's aggravation rights had expired, forwarded the claim to this Board. On May 15, 1990, we reopened the claim pursuant to our own motion authority and directed the insurer to pay temporary disability benefits.

On September 21, 1990, Dr. Bald reported that claimant would not be able to return to his regular work and recommended vocational assistance. Claimant requested the insurer to make a determination of his likely eligibility for such assistance, but the insurer denied the request. Claimant then requested the Director to conduct an administrative review of his likely eligibility. The Director dismissed the request for lack of jurisdiction. Claimant then requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

In this case, we are asked to review a decision of the Director pursuant to ORS 656.283(2) concerning vocational assistance. The Director concluded that the Workers' Compensation Division lacked jurisdiction to decide claimant's likely eligibility for vocational benefits, because his claim had been reopened under this Board's own motion authority pursuant to ORS 656.278. The Director's order provides, in part:

> "The Board's Own Motion reopening after the worker's aggravation rights have expired is neither an aggravation as defined by statute, nor a worsened condition as defined by Administrative Rule. Therefore, a Board's Own Motion reopening cannot be used as the basis for potential eligibility for vocational assistance.
>
> "Dismissal is warranted in this case because the issue of entitlement to benefits under the Board's Own Motion is outside the jurisdiction of the Workers' Compensation Division." (Ex. 18).

Without addressing jurisdiction, the Referee concluded that there was a likelihood of eligibility and remanded the matter to the Director for an order directing the insurer to determine whether claimant was entitled to vocational assistance. The Referee reasoned that the Director's rules did not restrict a claimant whose aggravations rights had expired from receiving vocational assistance.

At the outset, we note that the insurer has requested de novo review of the Referee's order. In reviewing the record made by the Referee, we may make findings of ultimate fact that differ from those made by the Referee. Colclasure v. Washington County School District No. 48-J, 117 Or App 128 (1992); Lasley v. Ontario Rendering, 114 Or App 543 (1992). The Director's order, however, may be modified only if it: (1) violates a statute or a rule; (2) exceeds the statutory authority of the agency; (3) was made upon unlawful procedure; or (4) constituted an abuse of discretion. ORS 656.283(2). With that clarification, we proceed with our review.

The first question is whether the Director erred in concluding he lacked jurisdiction to decide claimant's likely eligibility for vocational benefits. Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992). In this case, we conclude that the Director had such authority pursuant to ORS 656.283(2), which provides, in part:

> "If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on the matter."

Accordingly, we conclude that the Director had jurisdiction to decide the issue in dispute, i.e., claimant's potential eligibility for vocational services. The fact that, pursuant to the Director's rules, an injured worker may not be entitled to such services due to the own motion status of his claim does not deprive the Director of jurisdiction to make that determination.

Turning to the merits of the dispute, we must next determine whether claimant is likely eligible for vocational services. The determination is important, as it is a threshold requirement for receiving vocational rehabilitation benefits. OAR 436-120-035 provides, in part:

> "(1) The insurer shall determine if the worker is likely eligible for vocational assistance when one of the following occurs:
>
> "(a) The insurer receives a request for vocational assistance from the worker[;] or
>
> "(b) The insurer receives a medical report indicating a need for vocational assistance; or
>
> "(c) The worker has had 90 consecutive days of time loss.
>
> "(2) For likely eligibility to exist, the worker must have an accepted disabling claim or claim for aggravation[.]" (Emphasis supplied).

There is no dispute that the insurer has received a request from claimant for vocational services, as well as a medical report from his treating physician indicating a need for vocational rehabilitation services. The question is whether claimant has an "accepted disabling claim or claim for aggravation." The insurer contends that he does not, because his original accepted disabling claim was closed years ago and his aggravation rights have expired. Claimant responds that the fact that he had an accepted disabling claim in 1983 is sufficient for likely eligibility, regardless of whether his aggravation rights on that claim have expired.

The phrase "accepted disabling claim or claim for aggravation" is not defined. However, OAR 436-120-003 provides that, under the Director's vocational assistance rules, "a claim for aggravation will be considered a new claim." In light of this general applicability rule, we conclude that the Director's rules envision a "likely eligible" claim to be one from a claimant who is seeking vocational assistance as a result of an initial injury or because his claim has been reopened due to an aggravation under ORS 656.273.

This conclusion is further confirmed by OAR 436-120-040(2), which addresses eligibility for vocational assistance. The provision sets forth certain conditions which must be met in order for an injured worker to receive vocational assistance. In particular, OAR 436-120-040(2) provides that a worker must be likely to be or actually has been awarded permanent disability. It states as follows:

> "There is medical evidence which indicates that because of the injury, the worker will likely have permanent disability; or the worker has a Determination Order, Order of a Referee, Order on Review by the Workers' Compensation Board, decision of the Court of Appeals or an approved stipulation which grants permanent disability."

Inasmuch as claimant's aggravation rights have expired, he is precluded from receiving further benefits for permanent disability. ORS 656.278(1); State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603 (1990). Therefore, since each vocational assistance claim must be evaluated based on the circumstances arising from that particular opening of an initial injury claim or reopening of an aggravation claim, claimant would be unable to satisfy the criteria established by the Director in OAR 436-120-040(2) for vocational assistance eligibility. Our understanding of the Director's rules is consistent with the Director's own interpretation of them. Pursuant to DIF Bulletin 234 (April 16, 1991), the Director has announced that "when a worker's claim is reopened under the Board's Own Motion, the worker is not eligible for vocational assistance."

Consequently, the question becomes whether the Director's rules (which preclude a worker whose aggravation rights have expired from obtaining vocational assistance benefits to which he would otherwise have been entitled) is consistent with the Director's statutory authority. We conclude that the answer to that question is no.

ORS 656.340(6)(a) provides as follows:

> "A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available or suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment."

In order to implement this provision, ORS 656.340(7) grants the Director the following authority:

> "Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training."

It is axiomatic that administrative rules must be consistent with an agency's statutory authority. The agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule. Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992), citing Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988). We conclude that the Director's rule violates these basic principles.

Here, as discussed above, claimant would be eligible for vocational assistance benefits save for the fact that he has been disqualified by the Director because his aggravation rights have expired. In other words, he is unable to return to his previous employment or to any other available or suitable employment with his at-injury employer, and has a substantial handicap to employment. (Because of his compensable injury, claimant lacks the necessary physical capacities, knowledge, skills, and abilities to be employed in suitable employment). Such circumstances satisfy the specific prerequisites of ORS 656.340(6)(a). Moreover, that statute does not exclude from participation those workers who meet the specific prerequisites, but whose aggravation rights have expired.

We conclude that in disqualifying all workers from vocational assistance whose aggravation rights have expired, the Director's rule goes beyond the type of "time, place and manner" restrictions that the Director is authorized by ORS 656.340(7) to establish. We interpret section (7) as permitting the Director to establish conditions for providing vocational assistance services to workers, such as claimant, who satisfy the eligibility requirements set forth in section (6).

Such an interpretation is in keeping with the opening sentence of section (7), which states that "[v]ocational evaluation, help in directly obtaining employment and training shall be available under

conditions prescribed by the director." Thus, it is within the Director's authority to establish conditions for regulating the "time, place and manner" of vocational assistance services for an "eligible" injured worker. However, it is not within the Director's authority to further implement conditions which would exclude an injured worker from the statutory class of "eligible" solely on a ground that is entirely beyond the worker's control.

For example, the Director may condition the availability of services on a claimant's location and his participation in prior assistance programs, as well as the "nature and extent of assistance that may be provided." The implementation of such conditions is understandable in that each pertains to licensing and regulatory functions necessary for the Director to insure that vocational evaluations, services, and programs are being conducted, maintained, monitored, and completed in a manner consistent with Oregon statutory and administrative law. Moreover, it is also consistent with the specific rulemaking authority granted to the Director in ORS 656.340(9).

Such conditions are also consistent with the realities confronting an injured worker who seeks vocational assistance services. An injured worker can determine where he/she will reside. That worker's past performance and participation in vocational assistance programs are likewise within that worker's control. However, the mere passage of time and its impact on an injured worker's aggravation rights are matters that are not within a worker's control.

Here, claimant, an Oregon resident, has suffered a worsening of his compensable condition which his physician believes will prevent his return to regular work. Claimant has apparently never requested nor received vocational assistance as a result of his compensable injury. Thus, no previous assistance has been provided to him. In light of such circumstances, claimant satisfies not only the eligibility criteria of ORS 656.340(6), but does not fall within any of the statutory conditions limiting the availability, nature, and extent of vocational services.

As previously noted, the Director's rules seek to condition eligibility for vocational assistance on (among other factors) a worker's permanent disability award or the likelihood of such an award. See OAR 436-120-040(2). Such a requirement is understandable in that a permanent disability award is based on a permanent loss of earning capacity or a permanent loss of use or function. In most cases, the existence of a permanent disability award (or its likelihood) resulting from the initial opening or reopening of the claim is but another indicia of a "substantial handicap to employment" as set forth in ORS 656.340(6). Yet, it does not necessarily follow that the lack of a permanent disability award (or its likelihood) means that a worker has not suffered a "substantial handicap to employment" preventing his return to his previous employment or to any other available and suitable employment. Where, as here, a claimant satisfies the requirements of ORS 656.340(6), the fact that he is precluded from receiving further permanent disability benefits as a result of his compensable worsening does not likewise preclude him from receiving vocational assistance.

In declining claimant's request for vocational assistance, the Director's order relied on rules which purport to restrict claimant's eligibility for vocational assistance for a reason which is not in keeping with ORS 656.340(6) and (7). Since we consider the application of those rules to this claimant to contravene the statute, we modify the Director's order. ORS 656.283(2)(a) and (b).

In reaching this conclusion we are aware that the court has recently stated that a worker's right to vocational assistance is not unqualified. See Peacock v. Veneer Services, 113 Or App 732 (1992). In Peacock, supra, the court upheld the Director's rule which required that a worker be available in Oregon for vocational assistance. The court relied on the language in current ORS 656.340(7), (then numbered ORS 656.340(6)), which specifically gave the Director the authority to establish conditions for providing vocational assistance, including those relating to the worker's availability for assistance. Id. at 735.

Here, however, the basis in question for disqualification of workers is clearly different from the "time, place, and manner" conditions for providing assistance that are undoubtedly within the Director's authority to establish, and which the Peacock decision involved.

In Peacock, the claimant was denied vocational assistance because he resided out-of-state. Such a conclusion is consistent with the "availability" condition of ORS 656.340(7) in that the Director is required to establish conditions for providing vocational assistance. If, as in Peacock, a claimant resides

out-of-state and is not willing to travel to Oregon to receive vocational assistance, it is difficult for the Director to provide for and regulate vocational providers who are not subject to the Director's control and authority. Furthermore, if a claimant has established a "track record" of unsatisfactory or unsuccessful participation in vocational assistance, it is likewise reasonable for the Director to set conditions which would limit that claimant's future opportunities. Such circumstances would fall within the Director's "availability, nature, and extent" conditions for providing vocational services. For the reasons discussed above, this claimant, unlike the claimants in Peacock or our example, does not fall within the "availability, nature and extent" conditions of ORS 656.340(7).

Finally, we find no expression of legislative intent in ORS 656.340(6) and (7) to authorize the Director to disqualify workers from vocational assistance on the basis that they are no longer eligible to receive permanent disability benefits. Thus, the rationale expressed in Peacock, supra is not controlling in this instance.

Accordingly, we modify the Director's order. Specifically, the insurer is directed to provide claimant the same vocational assistance benefits he would receive if his aggravation rights had not expired.

Inasmuch as this order has resulted in increased compensation, claimant's attorney is awarded 25 percent of that increase not to exceed $3,800, payable directly to the attorney from the insurer. ORS 656.386(2); OAR 438-15-055(1); Simpson v. Skyline Corporation, 108 Or App 721 (1991).

ORDER

The Referee's order dated January 17, 1992 is modified. The Director's order is modified to provide that claimant is entitled to receive the same vocational assistance services he would receive if his aggravation rights had not expired. Claimant's attorney is awarded a fee equal to 25 percent of the increased compensation resulting from this order not to exceed $3,800, payable directly to the attorney from the insurer.

**Board Member Gunn, specially concurring:**

I write this special concurring opinion to express my agreement with the majority's concerns, but also my confidence about the ultimate outcome of this case once it reaches the Court of Appeals. I believe the court will reverse the Board's decision.

There is no doubt that claimant has a "substantial handicap to employment" as the result of his compensable injury. His condition has worsened to the point that his doctors state that he must find a new line of work and urge that he be given vocational assistance for that purpose.

With such evidence, claimant would be eligible for vocational assistance, except that his request was denied by the Director on the sole ground that his aggravation rights have expired; that is, because claimant has no right to receive any additional permanent disability award for the present worsening of his condition. The Director's reasoning is a non sequitor. Claimant has not asked for an additional permanent disability. This is not an aggravation claim case. Rather, because of his injury, he can no longer do his job, and his doctors have asked that he be given vocational assistance. Claimant would rather work for a living than become a public charge.

The Director has decided that claimant does not qualify. If my reading of two recent Court of Appeals decisions is right, the Director has the last word on who is eligible and who is not. For example, according to my reading of the court's decision in Peacock v. Veneer Services, supra, the Director has authority under ORS 656.340(6) to declare ineligible all injured workers whose disabling injuries were initially non-disabling for a period of time after the accident, or who have had triple by-pass surgery, or suffered a heart attack as the result of the injury. These bases for disqualification are no less arbitrary than the one the Board declares ultra vires in the present case. However, I am afraid that the Board's decision will be reversed, because as Judge Buttler said in his concurrence in Colclasure v. Washington County School District No. 48-J, 117 Or App 128, 135 (1992): "[c]oncededly, the statutory process dictated by ORS 656.283(2) is peculiar and, perhaps, unfair to claimants. However, that is a question for the legislature to resolve".

Of course, I would be glad to be proven wrong by a Court of Appeals decision affirming the Board's order in this case.

**Board Member Moller, specially concurring.**

I concur with the majority in all respects. I write only to add the following comments which I perceive to represent the Board's underlying approach to addressing a question of the validity of a Director's rule.

We have here concluded that the Director's rules impermissibly operate to exclude otherwise eligible workers from receiving vocational assistance when their aggravation rights have expired. Our decision is based on our conclusion that the Director's rules, as applied here, contravene the vocational assistance statutes. On other recent occasions, we have similarly concluded that a particular Director's rule could not validly be applied to the case before us. See e.g. Kevin Northcut 45 Van Natta 173 (1993); Timothy H. Krushwitz, 45 Van Natta 158 (1993).

We do not facilely reach such a conclusion. In a number of matters, the Legislature has expressly delegated to the Director the authority to "fill in the intristices in the legislation to aid in the accomplishment of the statute's purpose." U. Of O. Co-Oper. v. Dept. of Rev., 273 Or 539, 551 (1975). When that is the case, it is obviously not our place to pass on the wisdom of the Director's exercise of the delegated authority. Rather, our role is confined to ensuring that the Director's rules do not contravene either the letter or the intent of the statutes. See e.g. Wilson v. Workers' Compensation Dept., 86 Or App 207, rev den 304 Or 240 (1987); Kemp v. Workers' Comp. Dept., 65 Or App 659 (1983), mod 67 Or App 270, rev den 297 Or 227 (1984).

As explained by the majority, the Director has adopted rules here which do not merely mandate that certain requirements be met in order to be entitled to vocational assistance. Rather, the rule operates to irrevocably deny vocational assistance to any worker whose aggravation rights have expired. Cf. Kemp v. Workers' Comp. Dept., supra, 65 Or App at 662-63 (Department rule requiring that, if treatment exceeds prescribed number of visits, physician must submit a report justifying further treatment, is not inconsistent with statute because it does not actually limit the treatment). We have concluded that neither the letter nor the intent of the relevant statutes authorizes the limitation imposed here. To the contrary, the expressed Legislative policy relevant here is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c).

In light of the expressed Legislative policy and the absence of any indication of Legislative intent to the contrary, we are constrained to conclude that the Directors' rules at issue here operate to effectively rewrite the vocational assistance statute, rather than merely fill in the interstices of the statute. We reach our decision with the knowledge that either the courts or the Legislature may subsequently conclude that we have erred. Nevertheless, it is our responsibility to decide such issues as best we are able.

**Chair Neidig dissenting in part.**

I agree with that portion of the majority's holding that the Director has jurisdiction to determine whether claimant is eligible to receive vocational assistance. However, I respectfully disagree with the majority's conclusion that the Director has violated a statute by declining claimant's request for vocational assistance. See ORS 656.283(2)(a).

As recognized by the court in Peacock v. Veneer Services, 113 Or App 732, 735 (1992), a worker's right to vocational assistance is not unqualified. The court has emphasized that the specific statutory authority provided by present ORS 656.340(7) (then subsection (6)) permits the Director to prescribe conditions for providing vocational assistance.

In Peacock, the condition which resulted in the Director's denial of vocational assistance was the claimant's unavailability for assistance in Oregon. Here, the condition which claimant fails to satisfy is that his request for vocational assistance does not arise from an initial injury claim or an aggravation claim and that he will not receive a permanent disability award as a result of the "own motion"

reopening of his claim. As noted by the majority, the two conditions are unquestionably different. Nevertheless, the fact remains that the Director has prescribed a condition for vocational assistance that claimant's request has not fulfilled. The establishment of such a condition is in accordance with the Director's authority to adopt rules providing for "[s]tandards for the nature and extent of services as worker may receive[.]" ORS 656.340(9)(c) (Emphasis supplied.)

In light of the Director's broad discretion in prescribing conditions for providing vocational assistance, I do not consider the Director's decision to deny claimant's request for assistance based on the expiration of aggravation rights to constitute a violation of the Director's statutory authority under ORS 656.340(7) and (9). Moreover, as explained in the Director's Bulletin No. 234 (April 16, 1991), this prescribed condition is consistent with the 1988 amendments to ORS 656.278, which limited the Board's "own motion" authority to awarding additional temporary total disability in certain specified situations.

Based on the foregoing reasoning, I would hold that the Director has jurisdiction to consider claimant's request for vocational assistance and I would affirm the Director's order to the extent that claimant's request is denied because his aggravation rights have expired.

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February 17, 1993 Cite as 45 Van Natta 255 (1993)

In the Matter of the Compensation of
**MICHAEL PICKETT, Claimant**
Own Motion No. 93-0035M
OWN MOTION ORDER
Scott McNutt, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right knee injury. Claimant's aggravation rights expired on March 1, 1982. SAIF opposes the authorization of temporary disability compensation on the ground that claimant has not lost any wages as a result of his surgery.

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.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

We are persuaded that claimant's compensable injury has worsened requiring surgery. Furthermore, claimant is employed by the Coos County School District as a teacher. Therefore, he is engaged in regular gainful employment and was in the work force at the time of his disability.

However, SAIF recommends that time loss benefits be denied. It argues that claimant's surgery did not result in any loss of wages because, at the time of the surgery, he was on summer vacation from his teaching job. We disagree. Claimant need not prove an actual loss of wages to be entitled to temporary disability benefits. Claimant need only prove that, because of the worsening, he was less able to work in that he was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452 (1991), citing Smith v. SAIF, 302 Or 396, 401 (1986).

Here, claimant has established that his compensable worsening resulted in his being less able to work to such an extent that he was temporarily incapacitated from regularly performing work at a gainful and suitable occupation. Thus, claimant is entitled to temporary disability benefits.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning June 23, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625(b). The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARY E. REED, Claimant**
WCB Case No. 91-17238
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Brazeau, Westerband, and Gunn.

The self-insured employer requests review of that portion of Referee Brown's order that assessed a penalty for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issue is penalties. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The employer seeks review of that portion of the Referee's order that assessed a penalty for its allegedly unreasonable failure to pay temporary disability benefits when claimant became disabled due to a compensable worsening. We reverse.

Pursuant to ORS 656.262(10), claimant is entitled to a penalty if the insurer or self-insured employer "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, the employer contends that it had a legitimate doubt about its liability for temporary total disability compensation, because the evidence suggested that claimant was not a member of the work force at the time of her aggravation.

We agree that under Oregon law, a worker who has voluntarily withdrawn from the work force at the time of an aggravation of a compensable injury is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). A claimant is deemed to be in the work force if: (1) the claimant is engaged in regular gainful employment; or (2) the claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or (3) the claimant

is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work related injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989)

After our review, we agree that the employer had a legitimate doubt concerning its duty to commence temporary total disability payments. In this regard, the record indicates that at the time of her disability, claimant had not worked for approximately five years, had not attempted to return to work upon the completion of her work hardening program in 1989, and had not challenged the termination of her vocational assistance. Moreover, while she had returned to school in October 1990 and completed some skill-building classes, she quit in March 1991 with no indication from her treating physician that she could not continue school on a part-time basis. Given all of those factors, it was not clear at the time of her disability that claimant was making reasonable efforts to obtain employment or that it was futile for claimant to seek work. Therefore, we conclude that it was reasonable for the employer to believe that claimant had withdrawn from the work force at the time of her aggravation.

Based upon the evidence, we conclude that the employer had a legitimate doubt concerning its duty to commence payments to a worker it reasonably believed was not a member of the work force. Accordingly, we conclude that no penalty is appropriate under these circumstances.

ORDER

The Referee's order dated May 29, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which assessed a penalty against the self-insured employer for allegedly unreasonable resistance to the payment of compensation is reversed. The remainder of the Referee's order is affirmed.

**Board Member Gunn dissenting.**

The basis of the Referee's penalties finding was that there was "no factual indicia of withdrawal from the work force" to create a legitimate legal doubt. I agree.

The majority correctly states the standard on review: "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988) (Emphasis supplied). However, under that very same standard, the majority's conclusion errs inasmuch as any existing legitimate doubt was removed by "all the evidence available to the carrier." See Brown v. Argonaut Insurance Company, supra. I find that the majority has only looked at the evidence which supports a legitimate doubt and then for some uncertain reason attired itself with blinders as to the evidence that destroyed that doubt.

The majority found that there was legitimate doubt because: (1) claimant had not worked since 1986; (2) claimant did not attempt to return to work after completion of her work hardening program; (3) claimant did not challenge the termination of her vocational assistance; and (4) claimant returned to school in October 1990 and completed some skill building classes but quit in March 1991 with no indication from her treating doctor that she could not continue school on a part-time basis. I will address each basis for legitimate doubt, and the destruction of each by all of the evidence, as a whole, available to the carrier, in turn.

First, claimant had not worked since 1986. This fact indeed would create a legitimate doubt that claimant had removed herself from the work force, if there were no additional facts rebutting the doubt. However, in the present case, the legitimate doubt is destroyed by additional evidence.

On July 13, 1990 (received by the employer on July 31, 1990), Dr. Vranna reported that claimant "is looking for a job." (Ex. 10-1). Further, Dr. Vranna noted that: "She has set herself up with vocational rehabilitation in Grants Pass. Per her history, she herself took the initiative to do this." (Id).

On October 29, 1990 (received by the employer November 5, 1990), Dr. Vranna reported that claimant was taking secretarial courses and he recommended a home program of physical therapy to help claimant "stay in her vocational rehabilitation program." (Ex. 11-2).

On November 21, 1990 Dr. Vranna wrote directly to the insurer and informed that claimant "has begun participating in State Vocational Rehab through her own initiative." This was marked received on December 11, 1990.

On December 12, 1990 (received by the employer on December 24, 1990), Dr. Vranna reported on claimant's progress at Rogue Community College. (Ex. 13). On February 5, 1991 (received by the employer's attorney in June 1991), Dr. Vranna updated claimant's progress at Rogue Community College and forwarded a copy of his evaluation to "Irene, at Oregon Voc. Rehab. in Grants Pass." (Ex. 14-2). On February 21, 1991, Dr. Henderson noted that claimant was enrolled in the Rogue Community College in business. (Ex. 16-1). On April 5, 1991 (received by the employer April 16, 1991), Dr. Vranna commented on claimant's personal initiative in participating in vocational rehabilitation with State Vocational Rehabilitation and her efforts of restarting school. (Ex. 22-1). On September 26, 1991 (attended by the employer's attorney), claimant testified under oath that she attended vocational rehabilitation in the fall of 1990 and that the State Vocational Rehabilitation helped her get into school. (Ex. 32-7). She further testified that she attended Rogue Community College in the fall 1990 and winter 1991 terms and completed skill-building classes. (Tr. 32-12, 13).

The evidence is replete with facts that demonstrate that claimant was either in vocational rehabilitation or seeking work or both. Accordingly, I find that the fact that she did not work since 1986 is no longer a basis for legitimate doubt inasmuch as all of the above evidence was available to the carrier at the time of its decision on the matter. Furthermore, the employer's failure to independently investigate in light of all of the evidence available to it, is certainly unreasonable behavior. See Kenneth A. Foster, 44 Van Natta 148 (1992). Additionally, I find that any legitimate doubt on the basis that claimant did not attempt to return to work after completion of her work hardening program was also destroyed for the same reasons.

Moreover, I find that the majority's legitimate doubt basis of the fact that claimant chose not to embroil herself into litigation by challenging the termination of her vocational assistance is absolutely no basis for legitimate doubt. This is so for the most obvious reasons. In other words, a past choice to not be litigious ought not be a factor at all when making a work force determination, because the decision of whether to legally challenge an issue is made on many different grounds and most of them have nothing to do with what is or is not the operative facts of a legal issue down the road. Or put more simply, the fact that a person chooses not to litigate an issue that the person has a legal right to challenge is not determinative of whether that person has left the work force or not. Therefore, claimant may have been guilty of common sense. Nevertheless, the mere fact that she had the good sense not to get entangled in litigation should not be held against her.

Finally, I do not find that the fact that claimant returned to school in October 1990 and completed some skill-building classes but quit in March 1991 with no indication from her treating doctor that she could not continue school on a part-time basis as an indication of legitimate doubt that she removed herself from the work force since evidence after March 1991 (Exs. 22; 32) destroys that doubt and supports the ultimate finding that claimant had not removed herself from the work force.

In support of my findings, I point the majority to the following cases.

In William J. Amacker, 44 Van Natta 1798 (1992), the insurer's duty to pay temporary disability was triggered merely by the claimant's doctor, in a letter to the insurer, reporting that the claimant's "current occupation" was the contributing factor to his need for surgery and the doctor comparatively reported that the claimant's "employment history" was not the cause of his knee difficulties. Of note, there was no other legitimate doubt destroying evidence on the issue in the record, but this evidence was found sufficient to meet the claimant's burden of proof.

In Robert L. Adler, 44 Van Natta 1478 (1992), the insurer's duty to pay temporary disability was triggered and the insurer was found to have unreasonably resisted payment of compensation where there was a mere mention in a chartnote that the claimant "had a four month job as a manager of an apartment complex" and a medical intake report which listed the claimant's occupation as "Adler Investigation."

In Gerald D. Spencer, 44 Van Natta 298 (1992), the insurer's duty to pay temporary disability was triggered by the claimant's sworn affidavit pertaining to his job search efforts.

Therefore, I find that claimant's sworn testimony as attended by the insurer's attorney and at least eight medical reports with evidence meeting the work force requirement all received by the insurer and/or its attorney not only meets claimant's burden of proof as found by the Referee and the majority, but also removed all legitimate doubt on the employer's part as decided by the Referee.

Therefore, I dissent.

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February 17, 1993 Cite as 45 Van Natta 259 (1993)

In the Matter of the Compensation of
**DONNA M. SCHUMANN, Claimant**
WCB Case No. 92-01689
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myzak's order that set aside a Director's Order on Reconsideration as invalid, concluded that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD), and declined to remand the matter to the Appellate Unit. On review, claimant contends that the Referee's ruling violates her rights under the due process and privileges and immunities clauses of the Oregon Constitution and the United States Constitution.

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

Claimant's constitutional challenges rest on the assumption that no forum is available for claimant to litigate her right to permanent disability compensation. Since we agree with the Referee's conclusion that jurisdiction over claimant's permanent disability rests with the Appellate Unit, that assumption is premature. Accordingly, the constitutional challenges raised by claimant are not ripe for review. Moreover, claimant provides no argument in support of her position. The Board has previously declined to address constitutional challenges raised without a coherent supporting argument. Sandra L. Deel, 43 Van Natta 2482 (1991); Herman M. Carlson, 43 Van Natta 963 (1991). For these reasons, we decline to address the constitutional challenges raised by claimant on review.

ORDER

The Referee's order dated April 30, 1992 is affirmed.

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In the Matter of the Compensation of
**DEBORAH L. VILANJ, Claimant**
WCB Case No. 91-05652
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Barber's order that: (1) upheld the self-insured employer's partial denial of cab fare; (2) found that he lacked jurisdiction to address claimant's contentions regarding scheduled permanent disability; (3) affirmed an Order on Reconsideration awarding no scheduled permanent disability; (4) authorized the employer to offset an overpayment; and (5) found that claimant was not entitled to temporary disability from June 1990 through December 1990. On review, the issues are medical services, extent of unscheduled permanent disability, jurisdiction, offset, and temporary disability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Partial Denial of Cab Fare

We affirm and adopt that portion of the Referee's order regarding this issue.

### Extent of Unscheduled Permanent Disability

A March 14, 1991 Determination Order awarded claimant 13 percent unscheduled permanent disability. On reconsideration, claimant was found to have no permanent impairment and was awarded no unscheduled permanent disability. The Referee affirmed the Order on Reconsideration, finding that claimant had failed to prove permanent impairment as a result of her industrial injury.

Claimant asserts that she proved a chronic condition and, therefore, has permanent impairment. In making this contention, claimant relies on a closing examination performed by her treating physician, Dr. Takacs, D.O., stating that claimant had "marked decreased functional capacity as evid. by her inability to do her prev. form of employment, and she does put up with chronic discomfort, and she may warrant a 3% impairment as a result of that." (Ex. 8).

Under the applicable standards, "a worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition." Former OAR 436-35-320(5) (WCD Admin. Order 2-1991). Here, the only medical opinion regarding chronic condition impairment is Dr. Takacs' report cited above. However, we find it insufficient under the standards to warrant an award for impairment. First, we find that Dr. Takacs' statement that claimant "does put up with chronic discomfort" does not prove that she is "unable to repetitively use a body part due to a chronic and permanent medical condition." Furthermore, as pointed out by the Referee, Dr. Takacs stated only that claimant "may" be entitled to an award based on this discomfort, which does not rise to the required level of medical probability.

Therefore, we agree with the Referee that claimant failed to prove permanent impairment and that she is not entitled to unscheduled permanent disability. Consequently, we do not address claimant's assertion regarding an attorney fee.

### Jurisdiction/Extent of Scheduled Permanent Disability

Claimant properly requested reconsideration of the March 1991 Determination Order by the Director under ORS 656.268(4)(e). However, claimant's request was limited to the issue of unscheduled permanent disability. It was not until claimant filed her request for hearing following the issuance of the Order on Reconsideration that she raised the issue of scheduled permanent disability.

The Referee concluded that he lacked jurisdiction to address claimant's contentions regarding scheduled permanent disability because she had not raised the issue on reconsideration. Claimant objects to this conclusion, asserting that the issue is a "matter concerning a claim" under ORS 656.283(1) and, therefore, the Hearings Division had jurisdiction to address it.

Based on our finding above that claimant failed to prove permanent impairment, we conclude that, whether or not the Referee had jurisdiction to address the issue, claimant is not entitled to scheduled permanent disability.

Finally, we note that claimant, on review, asserts that the Order on Reconsideration is not valid because she requested an examination by a medical arbiter and no such examination was conducted. Claimant therefore contends that the Director did not comply with his statutory duties and that the case should be remanded back to the Director.

ORS 656.268(7) requires the Director to refer a claim to a medical arbiter if a party's objection on reconsideration to a notice of closure or determination order is based on a disagreement with the impairment findings used in rating the worker's disability. We have held that, under this statute, an Order on Reconsideration is invalid if the basis for objection is to the impairment findings and the Director fails to appoint a medical arbiter or submit the arbiter's findings for reconsideration. See Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

However, the Director's failure to comply with this mandatory procedure results in a voidable order, rather than one that is void ab initio. Brenton R. Kusch, 44 Van Natta 2222 (1992). The party that requested reconsideration of a Notice of Closure or Determination Order and objected to the impairment findings may, at hearing, withdraw any objection to the impairment findings and thereby waive its right to examination by a medical arbiter. In such cases, the Order on Reconsideration is not declared invalid. See Randy M. Mitchell, 44 Van Natta 2304 (1992).

Here, we agree that claimant objected to the impairment findings in her request for reconsideration. However, it appears that the Director, prior to the issuance of the Order on Reconsideration, scheduled claimant for a medical arbiter's examination but claimant did not attend because she had been scheduled for brain surgery. (See Ex. 33-4). Furthermore, at hearing claimant did not argue that the Order on Reconsideration was invalid for lack of a medical arbiter's report.

We conclude that, under these circumstances, claimant withdrew her objections to the impairment findings, thereby waiving her right to an examination by a medical arbiter. Consequently, we do not declare the Order on Reconsideration to be invalid.

Offset

The employer paid claimant the 13 percent unscheduled permanent disability awarded by the Determination Order. Having found that claimant was not entitled to any unscheduled permanent disability, the Referee allowed the employer to offset this overpayment against any future compensation. Claimant objects to the Referee's authorization of an offset, arguing that an offset is allowed only in the circumstances outlined by ORS 656.268(14), none of which are applicable here.

As pointed out by the employer, we do not limit a carrier's ability to offset overpayments to those events contained in ORS 656.268(14). Overpayments made after a Determination Order has become final may be offset against future compensation after the carrier obtains approval from a Referee or the Board. Travis v. Liberty Mutual Ins., 79 Or App 126, 129 (1986); Forney v. Western States Plywood, 66 Or App 155 (1983). Here, having agreed with the Referee that claimant is not entitled to any unscheduled permanent disability, we find that an overpayment was created by the employer's previous payment of the Determination Order award of 13 percent. Therefore, the employer is entitled to offset this overpayment against future awards of permanent disability compensation. See Jose E. Sanchez, 42 Van Natta 2313 (1990).

Temporary Disability

The Determination Order also awarded temporary disability from November 30, 1989 through December 6, 1990 "less any time the worker was withdrawn from the workplace." Claimant quit her job

in June 1990. The employer, finding that claimant had withdrawn from the workplace when she quit, did not pay any more temporary disability from that date. Claimant asserts that she is entitled to temporary disability from that date through December 6, 1990, asserting that she left her job because she was physically incapable of performing it and that she searched for work up through her December 6, 1990 medically stationary date.

We find that the issue in the present case is one of substantive entitlement to temporary disability benefits, as claimant's claim has been accepted, closed and temporary disability benefits have been paid. For the following reasons, we conclude that claimant is not substantively entitled to temporary disability benefits after June 1990. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992).

A worker is not entitled to temporary disability if the worker is not employed and the resulting wage loss is not caused by the compensable injury. See Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991). Here, the evidence demonstrates that claimant quit her job for personal reasons rather than because she was physically incapable of performing the work. At the time that she quit, Dr. Takacs had released claimant for modified employment. (Ex. 6-1). Dr. Takacs later indicated that, at the time she quit, claimant was physically capable of performing her job duties. (Ex. 20-2). Therefore, we conclude that claimant's resulting wage loss when she quit her job was not caused by her compensable injury. Consequently, she was not entitled to temporary disability after that date.

ORDER

The Referee's order dated January 24, 1992 is affirmed.

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February 18, 1993 Cite as 45 Van Natta 262 (1993)

In the Matter of the Compensation of
**JAIME BARACIO-ROMERO, Claimant**
WCB Case No. 90-20174
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Harri's order that: (1) set aside the Determination Order as premature; (2) did not rate his permanent partial disability; and (3) did not award an out-of-compensation attorney fee. On review, the issues are premature closure, attorney fees and, if the claim was not prematurely closed, extent of unscheduled 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.

Claimant's January 26, 1990 back and left shoulder injury was accepted by the SAIF Corporation, on behalf of the noncomplying employer. Claimant treated with a chiropractor until March 16, 1990. On or about March 19, 1990, claimant was incarcerated. On July 12, 1990, while incarcerated, claimant sought treatment for rib, neck and back pain. Jail records indicate that claimant was "released to INS for deportation" on September 7, 1990.

An October 9, 1990 Determination Order closed claimant's claim, found him to be medically stationary as of March 16, 1990, and awarded no permanent disability compensation.

On December 12, 1990, Dr. Stringham examined claimant, recommended against further chiropractic treatment, requested authorization for a work hardening program, and provided pain medication.

FINDING OF ULTIMATE FACT

Claimant was not medically stationary on October 9, 1990.

## CONCLUSIONS OF LAW AND OPINION

Claimant argues on review as he did at hearing, that he was medically stationary on March 16, 1990, consistent with the findings of the Determination Order. SAIF, however, contended at hearing that claimant became medically stationary on July 13, 1990, the date claimant last sought treatment prior to the issuance of the Determination Order. Since SAIF raised the issue of claimant's appropriate medically stationary date, the Referee correctly considered all matters surrounding that issue. The Referee concluded that claimant was not medically stationary on March 16, 1990. He, therefore, set aside the October 9, 1990 Determination Order as having been prematurely issued. We agree with the Referee's conclusion based on the following analysis.

Under ORS 656.005(17), a claimant is medically stationary when no further material improvement is anticipated through treatment or the passage of time. Post-closure changes in claimant's condition are not considered. Scheuning v. J. R. Simplot and Co., 84 Or App 622, 625, rev den 303 Or 590 (1987). The March 16, 1990 chart note of Dr. Anderson, claimant's then-treating physician, notes continuing neck, upper back and left shoulder pain and reschedules claimant for further treatment on the following Monday. (Ex. 3-3). In reviewing his notes after the fact, Dr. Anderson stated: "At the time of the patient's last visit, he was still essentially on time loss authorization, and more likely than not would have remained so for one, perhaps two, additional weeks beyond that, but certainly not to extend past the end of March 1990. At the time of last treatment, the patient was also not considered to be medically stationary." (Ex. 10-3). Clearly, Dr. Anderson anticipated further improvement on March 16, 1990. There is no contrary evidence in the record.

Claimant was next examined in jail in July 1990 while awaiting deportation. The examination revealed rib, neck and back pain, resulting in a treatment regimen that included medication and exercise. We conclude that the prescribed treatment plan indicates that the examining physician anticipated further improvement through medical treatment. Thus, claimant was not medically stationary when treated in jail. (Ex. 7).

Claimant was subsequently deported on September 7, 1990 and was next seen for evaluation and treatment on December 12, 1990. At that time, Dr. Struckman noted that claimant's treatment had been complicated by his incarceration and that claimant was obviously deconditioned. Struckman recommended work hardening. From this evidence, we conclude that claimant's condition had still not reached a medically stationary status on December 12, 1990. (Ex. 12-2).

As previously noted, claimant's claim was closed by a Determination Order dated October 9, 1990. Claimant was not medically stationary on that date, however, and we therefore conclude that his claim was prematurely closed. Scheuning v. J. R. Simplot and Co., supra. [1]

Finally, claimant asserts that the Referee improperly failed to award an attorney fee under ORS 656.386(2). We agree. Therefore, we award claimant's attorney a reasonable attorney fee of 25 percent of the increased compensation made payable by the Referee's Opinion and Order up to a maximum of $1,050. OAR 438-15-045.

## ORDER

The Referee's order dated January 28, 1991, as reconsidered May 14, 1991 and July 1, 1991, is affirmed in part and modified in part. The order is modified to award claimant's attorney a reasonable attorney fee of 25 percent of the increased temporary disability compensation made payable by the Referee's order up to a maximum of $1,050, payable directly to claimant's attorney out of and not in addition to the compensation. The remainder of the Referee's order is affirmed.

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[1] Despite our conclusion that claimant was not medically stationary as of October 9, 1990, we note that the 1990 amendments to ORS 656.268, which require an objecting party to first seek reconsideration of a Determination Order with the Director, do not apply in this case. See Or Laws 1990 (Special Session), ch. 2, § 54(3). Because the October 9, 1990 Determination Order found claimant medically stationary on a date prior to July 1, 1990, he was entitled to seek direct review of the order by requesting a hearing. See Rhonda E. Purdy, 44 Van Natta 2549 (1992).

In the Matter of the Compensation of
**JOSEPH T. CARTISSER, Claimant**
WCB Case No. 91-07118
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
David Jorling, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Spangler's order that upheld the self-insured employer's denial of his occupational disease claim for coronary artery disease. In his brief, claimant moves to strike documents that are appended to the employer's Respondent's Brief. On review, the issues are motion to strike and compensability. We deny the motion to strike, and affirm the Referee's order.

Motion to Strike

Claimant moves to strike the eight-page appendix to the employer's Respondent's Brief, which consists of minutes of testimony before the Senate Labor and Industries Committee during the 1961 Oregon legislative session. In support, he argues that the minutes are not in the record and have not been authenticated, and that no request for judicial notice has been filed.

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2) (ORE 201(b)). Here, the disputed evidence is a record of the legislative history concerning the statute in dispute. We often consider legislative history in determining the legislature's intent in enacting, amending or repealing legislation. Inasmuch as claimant does not contest the accuracy of the minutes, we conclude that we may properly take administrative notice of the minutes. Claimant's motion is denied.

Compensability

We adopt the Referee's order, with the following supplementation.

In order to rebut the fire fighter's presumption in ORS 656.802(4), the employer must prove by clear and convincing medical evidence that the cause of claimant's coronary artery disease (CAD) is unrelated to his employment as a fire fighter. To be "clear and convincing," the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

Based on the thorough and well-reasoned opinion of Dr. Toren, we find it highly probable that claimant's employment as a fire fighter did not contribute to the development of his CAD. Accordingly, we conclude that the employer has sustained its burden of proving that claimant's claim is not compensable.

ORDER

The Referee's order dated October 3, 1991 is affirmed.

**Board Member Hooton dissenting.**

This case involves an application of the fire fighter's presumption at ORS 656.802(4). Under the presumption, claimant's coronary artery disease is presumed to be compensable unless the employer can show, by clear and convincing evidence, that claimant's coronary artery disease is not caused by his employment exposure. SAIF v. Bales, 107 Or App 198 (1991). To be "clear and convincing," the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). The majority asserts that on the basis of the report of Dr. Toren, and his testimony at hearing, the employer has carried that burden. I disagree.

The report of Dr. Toren, even insofar as it is supported by the report of Dr. DeMot, cannot constitute clear and convincing evidence that the employment exposure did not cause the claimant's coronary artery condition for two distinct reasons. First, the analysis provided by Dr. Toren and duplicated by Dr. DeMot relies upon an inappropriate standard of proof. Second, neither the reports nor the testimony of Dr. Toren at hearing address claimant's occupational exposure as a potential cause.

Case law has established that claimant need not demonstrate medical causation to a scientific certainty. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985). The appropriate measure of certainty in a workers' compensation claim is reasonable medical probability. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968). In this case, it would be asinine to suggest that the employer had failed because it demonstrated to a scientific certainty that claimant's condition did not result from his employment. Clearly, the higher burden of proof would include the lesser. That, however, is not what Dr. Toren has done.

In the guise of strict scientific reasoning, Dr. Toren argues that claimant cannot establish the causal connection because science has not been able to demonstrate a concrete relationship between firefighting activities and coronary artery disease. That is not the question at issue. Despite the fact that claimant's treating physician and Dr. Welch rely upon numerous medical articles published in respected medical journals to support their conclusion that claimant's coronary artery disease is caused by claimant's employment, Drs. Toren and DeMot decline to accept the probability established by those articles and studies, or even to discuss the anatomical factors that would or would not be affected by firefighting activities. Instead, Dr. Toren focuses on the studies cited by Dr. Welch, which he criticizes by challenging research methodologies, statistical inadequacies and controls, all hallmarks of scientific research. Dr. Toren's conclusion is that studies which assert a probable relationship between carbon monoxide exposure and coronary artery disease are unreliable because they do not measure up to the standard of scientific certainty. The question, however, is whether the relationship is medically probable. The secondary issue of whether that medical probability can be scientifically substantiated, while interesting, is wholly irrelevant. Because we do not demand that high standard, the basis for Dr. Toren's reliability challenge is improper in the context of workers' compensation litigation.

Ironically, the principal difficulty with Dr. Toren's analysis plays directly into the purpose for ORS 656.802(4). The legislative history, provided by the employer with its brief on review, makes it apparent that the legislature recognized the difficulty in proving or disproving a causal relationship between heart and lung disorders and a fire fighter's occupational exposure. Consequently, the legislature recognized the very weakness, that Dr. Toren discusses here. In response to that weakness, they created a presumption shifting the burden of proof to the employer to prove the claim not compensable.

Though not explicitly discussed in the legislative history, the difficulty with establishing causation exists on multiple levels but primarily derives from the inability, as noted by Dr. Toren, of providing proper controls for research purposes. Not only is it difficult, if not impossible, to control for known risk factors, it is also impossible to isolate potential risk factors for this specific population group. For example, when testing fire fighters generally, it would be impossible to control for physical and emotional stress, while testing the impact of carbon monoxide exposure. It is likewise impossible to control for only isolated fume exposures.

Fire fighting is an emergent occupation. It is unlikely that fire fighters are aware of the toxic chemicals which may be present in the smoke generated by any one particular fire, certainly not in the many fires which they may fight in the course of a career. When a house is burning in a populated residential area it is not possible to remove furnishings and plastics whose fumes may be extremely toxic, or even deadly. The fire fighter does not know if the property has recently been used as a "crack" laboratory, or was built with pristine materials whose only toxic threat is carbon monoxide. Because of the destructive nature of fire, it is difficult to determine after the fact what toxic exposures a fire fighter may have encountered, or the level of that exposure.

By advising us that medical research which demonstrates a probable relationship between firefighting activities and coronary artery disease is scientifically deficient, Dr. Toren only confirms what the 1961 Legislature already knew. However, that is not the basis for a denial of the claim. Rather, it is the explanation for the presumption in the first instance.

Indeed, much of Dr. Toren's report and testimony indicate his belief that the fire fighter's presumption regarding causation is based on a faulty scientific premise that should be disregarded, a result which, if we decide the issue on the basis of the current state of the law, we are unable to accommodate even if so minded. We decide cases, but we do not legislate. It is legislation that Dr. Toren expects of us, however, and legislation is what the majority accomplishes.

The evidence establishes a philosophical bias that prevents Dr. Toren from objectively analyzing causation in the terms required by the Act. As a consequence, his conclusions, no matter how accurate they may be scientifically, are functionally worthless in the resolution of the present claim. His bias destroys any credibility his scientific stature might otherwise afford. He is not a reliable witness on the issue presently before the Board, and his testimony must be disregarded.

Dr. DeMot accepts and asserts the same scientific premise that undermines Dr. Toren's conclusions. His reports are likewise unreliable and unacceptable.

Dr. Toren does not end his analysis with a consideration of that medical research which establishes a probable connection between fire fighting and coronary artery disease. He goes on to analyze the claim in light of the risk factors that are scientifically known to contribute to the probability of coronary artery disease. He identifies four major and two minor risk factors. Of these six factors, he finds that claimant has two. He concludes, therefore, that claimant's high cholesterol and tobacco use are the causes of claimant's coronary artery disease.

The essential weakness in Dr. Toren's argument, however, is his unwillingness to consider the probable effects of any potential or probable cause, including firefighting activities, unless that causal relationship is established with the same scientific certainty as the six known risk factors he is willing to accept. He makes no effort to evaluate potential factors that other cardiologists recognize, and leading medical journals report, as probably causative of coronary artery disease.

On the other hand, his argument also involves a weakness based upon the very statistical analysis he applies to determine causation. The Court has previously considered and rejected the possibility of a defense based on statistical factors where there is medical evidence supporting a probable relationship. In other words, it is not sufficient to show that statistical probability supports a noncompensable cause to defeat a claim for compensation where there is evidence that supports a medically probable relationship between compensable causal factors and that same disease process. No matter how rarely such an impact may occur, if there is medical evidence of such a relationship in the case at hand, the fact that statistical probability would support another cause is not sufficient to defeat the claim. Stedman v. Garrett Freightlines, 67 Or App 129 (1984). While Dr. Toren is an exceptionally articulate cardiologist, with a clear understanding of the principles of logic and scientific analysis which permits him to disguise a statistical defense as sound medical reasoning, the effect remains the same. The Board should use great care in accepting a statistical defense to compensability in any instance given the prior treatment that defense has been afforded by the courts.

Even if the report and testimony of Dr. Toren is acceptable under the standard of proof appropriate to workers' compensation claims, I must find that the employer has failed to carry its burden of proving noncompensability by clear and convincing evidence. I make that determination based on the weight to be accorded the reports of Dr. Punja, claimant's consulting cardiologist, an expert of equal professional education and stature as that of Dr. Toren, as confirmed by the reports of Dr. Welch, an internist with 20 years experience as physician to the Portland Police and Fire Disability Board. Dr. Welch's expertise in the relationship between a fire fighter's occupational exposure and subsequent disability is considerable and makes him the most significant expert to present an opinion in the present claim. Abbott v. SAIF, 45 Or App 657 (1980).

In Erck v. Brown Oldsmobile, 311 Or 519 (1991), the Supreme Court noted that the Workers' Compensation Law places few restraints on the Board's ability to evaluate evidence. In that case, the court decided that it lacked authority to reverse the Board's findings on credibility because the statute did not require the Board to defer to the findings of the Referee. In like manner, the statute does not require the Board to give deference to the medical findings of any particular practitioner in any given case. In keeping with the statutory requirements, the Board is free to weigh the evidence in any manner it deems appropriate.

Nevertheless, the Board has, both implicitly and explicitly, ratified rules regarding the weighing of expert testimony originally adopted by the Court of Appeals to guide its judgment in the evaluation of that evidence when it retained de novo review authority. Despite the fact that de novo review has given way to substantial evidence review at the Court of Appeals, the Board has continued to give lip service to the wisdom and principles of those rules. Having ratified those rules, we must now

consistently apply them, and submit the application of the rule to the specific review of the Court of Appeals as a question of law. If the court declines to determine whether the rule we have adopted is appropriately and consistently applied, the preponderance of the evidence standard and the requirement that proof be based upon medical probability become vocalizations only, and the law is no more.

Each of the parties must be able to rely upon a consistent and fair application of the rules and principles expressed in Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986); and Abbott v. SAIF, supra. To do otherwise is to expose the review of the Board as ad hoc and result oriented, a review antithetical to justice and fairness and the letter and spirit of the Workers' Compensation Law. ORS 656.012(2).

Under an appropriate application of the Abbott rule, adopted by this Board, the claimant has established the compensability of his coronary artery disease claim. The greater expertise of Dr. Welch in dealing with disability resulting from the occupational hazards of firefighting tips the scales in favor of compensability. Consequently, it is impossible for the employer to have proven by clear and convincing evidence that the claim is not compensable.

The majority has changed the burden of proof in a workers' compensation case for coronary artery disease to scientific certainty. The majority also ignores its own ratification of specific rules for the weighing of evidence to deprive this claimant of a compensable claim. Therefore, I respectfully dissent.

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February 18, 1993 Cite as 45 Van Natta 267 (1993)

In the Matter of the Compensation of
**DAVID M. CRYMES, Claimant**
WCB Case No. 91-15603
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
William J. Scheiderich, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Schultz' order that set aside its denial of claimant's binaural hearing loss. On review, the issue is compensability.

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

The employer argues that claimant's hearing loss does not satisfy the definition of a "compensable injury" because it has not required medical services or resulted in disability. ORS 656.005(7)(a). We disagree.

ORS 656.005 does not define "medical services." The court in Finch v. Stayton Canning Co., 93 Or App 168 (1988), while pointing out that there is no definition for the term "medical services" as found in ORS 656.005(7)(a), held that the claimant who had symptoms, and sought the assistance of a physician for treatment even though no actual treatment was recommended, had received the required "medical services" and suffered a compensable occupational disease. The court said, "That no treatment is available for an injury or disease does not mean that a claimant is not injured or sick." Id. at 173; Linda L. Smith, 41 Van Natta 2114 (1989).

Here, claimant sought treatment for his increased hearing loss from Dr. Lundeberg, otolaryngologist, who performed a physical examination, audio tests, and recommended future yearly hearing examinations. Furthermore, Dr. Lundeberg opined that claimant's incremental hearing loss since 1989 was due in major part to the noise exposure he experienced in his work as a firefighter. (Ex. 16). We find that the treatment claimant received from Dr. Lundeberg constitutes medical treatment within the meaning of ORS 656.005(7)(a). Finch v. Stayton Canning Co., supra; Linda L. Smith, supra.

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 compensability issue 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 May 20, 1992 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, to be paid directly to claimant's attorney by the self-insured employer.

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February 18, 1993 Cite as 45 Van Natta 268 (1993)

In the Matter of the Compensation of
**DONALD G. DORRY, Claimant**
WCB Case Nos. 90-21645 & 90-10657
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Liberty Northwest Insurance Corporation requests review of Referee Black's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim. On review, the issue is compensability and responsibility. We reverse.

FINDINGS OF FACT

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

The Referee found that claimant "continued to have intermittent low back pain and weakness" after his February 1987 injury. Instead, we find that, although claimant occasionally had low back pain following the 1987 injury (Tr. 27), his back was doing well and he was performing auto body and fender repair work without difficulty, prior to the sudden onset of back pain on April 10, 1990 (see Tr. 7-8, 14, 17, 18, 20, 22, Ex. 22). Claimant last received treatment for his 1987 injury in approximately March of that year. (Ex. 5-1).

Claimant's April 10, 1990 injury while working for SAIF's insured was a material contributing cause of his subsequent disability and need for treatment for a back strain.

CONCLUSIONS OF LAW AND OPINION

The Referee decided this matter under the 1990 amendments to the Workers' Compensation Law. Inasmuch as claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we too analyze this matter under the 1990 Act. Or Laws 1990 (Special Session), ch. 2, §54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee apparently viewed claimant's 1987 back injury with Liberty Northwest's insured as a "preexisting condition" and, therefore, reasoned that responsibility for the back condition shifts to SAIF only if the April 1990 incident is proved to be the major contributing cause of the subsequent disability and need for treatment. The Referee relied on 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."

Subsequent to the Referee's order, the Court of Appeals recently rejected this line of reasoning in SAIF v. Drews, 117 Or App 596 (1993). In Drews, the court held that ORS 656.005(7)(a)(B) does not apply in cases where responsibility for a particular condition is being assigned pursuant to ORS 656.308(1). Accordingly, ORS 656.005(7)(a)(B) does not apply here.

In cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. See ORS 656.308(1); Drews, supra. A new compensable injury is established by proof that claimant's subsequent work exposure was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Drews, supra. The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a), 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

After our review, we conclude that claimant sustained an actual, independent compensable injury with SAIF's insured. He was working for SAIF's insured when he suffered a sudden onset of back pain on April 10, 1990. (Tr. 20, 22). The next day, he sought treatment at a hospital emergency room (see Ex. 12) and, thereafter, from Drs. Carter and Kitchel. Drs. Carter and Kitchel recorded claimant's reduced range of back motion due to pain associated with claimant's work on April 10. (Exs. 16, 19). Dr. Kitchel also noted a muscle spasm in claimant's back, diagnosed a musculoligamentous strain and restricted claimant's return to work. (Ex. 19). These are sufficient objective medical findings of an injury. See Robertson, supra. See also Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992).

Furthermore, Drs. Carter, Kitchel and Abraham all opined that the April 10, 1990 incident at SAIF's insured was the major contributing cause of claimant's need for back treatment. (Exs. 22-1, 24-1, 25-1, 26). That medical evidence is uncontradicted.

In contrast, we find insufficient medical evidence relating claimant's current back condition to his 1987 back strain injury. Although claimant conceded that he continued to have occasional back pain following the 1987 injury (Tr. 27), he also testified that his back was doing well and did not interfere with his work before the April 10, 1990 incident. (Tr. 7-8).

Therefore, we conclude that claimant suffered a compensable injury while working for SAIF's insured. Consequently, SAIF is responsible for the resulting disability and need for medical services. ORS 656.308(1); Drews, supra

Claimant is entitled to an assessed fee for services on review. 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 $350 is a reasonable assessed fee for claimant's counsel's efforts on Board review, to be paid by SAIF as the responsible 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 presented, and the value to claimant of the interest involved.

## ORDER

The Referee's order dated March 29, 1991 is reversed. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The SAIF Corporation's denial is set aside and the "new injury" claim is remanded to SAIF for processing according to law. The Referee's attorney fee award to claimant's attorney shall be paid by SAIF, rather than Liberty Northwest. For services on Board review, claimant's attorney is awarded an assessed fee of $350, to be paid by SAIF.

In the Matter of the Compensation of
**DAVID M. FOOTE, Claimant**
WCB Case No. 91-12894
ORDER ON REVIEW (REMANDING)
JR Perkins III, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

The self-insured employer requests review of Referee Peterson's order which: (1) declined to dismiss as untimely claimant's request for hearing from the employer's denial of claimant's occupational disease claim for carpal tunnel syndrome; and (2) set aside the employer's denial. In its appellant's brief, the employer contends that claimant's hearing request should have been dismissed because it was not "ripe" and that it was untimely. On review, the issues are dismissal, timeliness and compensability. We remand.

FINDINGS OF FACT

We adopt the findings of fact of the Referee with the following supplementation.

By letter dated January 8, 1991, the employer's claims administrator notified claimant that the employer had scheduled an independent medical examination (IME) for January 22, 1991 at the Western Medical Consultants' offices in Portland. (Ex. 3). By letter dated January 14, 1991, claimant notified the employer that he would be unable to attend the scheduled IME. Claimant explained that it would be necessary for his grandparents to drive him to the examination and that they were "afraid of the conditions [in the Gorge] at this time." (Ex. 4-2). By letter dated February 11, 1991 the employer notified claimant that it had rescheduled the IME for March 4, 1991 consistent with the time specified by claimant that he would be able to attend the exam. (Ex. 5). Claimant failed to appear. (Ex. 6).

On January 30, 1992, the employer, through counsel, submitted a Motion to Dismiss to Assistant Presiding Referee Lipton, which included a request that the hearing scheduled for February 14, 1992 be dismissed for claimant's failure to appear at the scheduled IMEs. The record does not reflect that any action was taken on the employer's motion either prior to or at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

Concluding that it was not possible from the record to determine when claimant received notice of the employer's denial, the Referee was unable to determine whether claimant's hearing request was filed within 60 days of his notification of the denial. See ORS 656.319(1)(a); Thomas E. Edison, 44 Van Natta 211 (1992), rev'd on other grounds SAIF v. Edison, 117 Or App 455 (1992). Consequently, the Referee declined to dismiss claimant's hearing request as untimely. Turning to the merits of claimant's occupational disease claim, the Referee found that claimant's work activities were the major contributing cause of his right carpal tunnel syndrome. Accordingly, the Referee set aside the employer's denial.

On review, the employer contends that claimant's hearing request was untimely because, even if he filed his request within 180 days after being notified of the denial, he failed to establish "good cause" for the untimely filing. Even assuming that we agreed with the employer that the hearing request was untimely filed, we would still disagree with the contention that claimant has not established "good cause."

The test for determining whether "good cause" exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71N(1) and former ORS 18.160. Anderson v. Publishing Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 71 Or App 234, 237 (1985).

Here, claimant testified that, after February 1991, he lived in The Dalles with the mother of his children and, occasionally with friends. (Tr. 13, 21). The denial was mailed to claimant's aunt's residence by certified mail on March 11, 1991. (Ex. 7-3; Tr. 12). There was no return receipt and

claimant testified that he did not receive the employer's denial. (Tr. 21, 31). However, in June 1991, after making several attempts to determine the status of his claim, claimant retained an attorney and, sometime between June and September 1991, the attorney notified him that his claim had been denied. (Tr. 18, 21-25). Claimant subsequently filed a hearing request on September 9, 1991. Under these circumstances, we conclude that claimant has established good cause for filing a late hearing request. See International Paper Co. v. Cress, 104 Or App 496 (1990); James R. Barnett, 44 Van Natta 834 (1992).

The employer also renews its contention that claimant's request for hearing should be dismissed because claimant twice failed to attend a scheduled IME and, therefore, claimant's request for hearing was not "ripe." The Referee did not address this issue in his order. However, the record establishes that the issue was raised in a prehearing motion to dismiss. Consequently, we address it here.

The Workers' Compensation Law provides little assistance in resolving the present dispute. ORS 656.325(1)(a) provides in pertinent part that, if a worker refuses to submit to a medical examination requested by the self-insured employer, "the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place." OAR 436-60-090(6) sets forth the procedure by which the employer may apply to the Compliance Section for the Director's consent to suspend a workers' right to compensation when the worker fails to submit to a medical examination. In this claim, however, the employer issued its denial on March 11, 1991. There is, therefore, no compensation to suspend.

There is a basis upon which the employer's request may be deemed appropriate and reasonable, however. OAR 438-06-071(1) provides, in pertinent part, that claimant's request for hearing may be dismissed if claimant has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days. In this case, no unjustified delay of the hearing occurred. However, had the employer requested a continuance in order to obtain its IME, and claimant had failed to appear for the rescheduled IME, dismissal of the request for hearing would be appropriate. See Ring v. Paper Distribution Services, 90 Or App 148 (1988) (Referee may dismiss hearing request if claimant's refusal to submit to an IME caused an unjustified delay in prosecution of the claim which would warrant dismissal under the Board's rules).

It is possible for us to resolve this issue by noting that the employer did not request a continuance for the purpose of obtaining an IME, but rather requested the dismissal of the request for hearing. Because there is no basis for the relief requested, the motion could be denied and the claim otherwise finally resolved. We find, however, that to do so would violate the spirit, if not the letter, of the law.

ORS 656.283(7) provides that "the referee is not bound * * * by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." This requirement that the referee work to achieve substantial justice is applicable to the Board as well. ORS 656.295(6) provides that "the board may affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as it determines to be appropriate." The guidelines governing the discretion of the Board on review are the substantial justice requirement of ORS 656.283 and the purposes and objectives statement found at ORS 656.012.

The evidence presented in this record supports a reasonable inference that the conduct of claimant in failing to attend two scheduled IMEs prevented the employer from obtaining medical evidence bearing upon the relationship of claimant's employment to his carpal tunnel syndrome. The resolution of such a question characteristically 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). If claimant's failure to attend the IMEs prevented the employer from obtaining evidence in support of its denial, the actions of claimant have prevented any semblance of substantial justice in the resolution of the claim.

Because claimant did not appeal the denial of March 11, 1991 until September 6, 1991, we cannot conclude that the employer failed to act diligently in protecting its rights under the statute by failing to request an order requiring claimant's attendance for an IME prior to its motion of January 30, 1992. That conclusion is further supported by the record, which demonstrates that the request for hearing was originally dismissed as untimely on motion of the employer.

In keeping with the requirement that we conform the proceedings both at hearing and on review to accomplish the objective of achieving substantial justice, we construe the employer's motion as a motion for continuance to obtain an IME. Because it appears that claimant's conduct may have prevented the employer from adequately preparing its case at hearing, we remand to the Referee for entry of an interim order requiring claimant to attend an IME, which shall be scheduled in accordance with the terms of all applicable statutes or rules. Should claimant fail to attend the rescheduled IME, causing an unjustified delay in the hearing of more than 60 days, the Referee is directed to reconsider the employer's motion to dismiss under the terms of OAR 438-06-071(1).

After the IME is conducted and results of the examination are reported, the Referee may take any further evidence or testimony from either party required by substantial justice, including claimant's right to cross-examine the IME doctor(s) and present rebuttal evidence. Thereafter, the Referee shall determine the compensability of the claim and issue a final, appealable order.

Finally, on remand before the Referee, the parties shall not be permitted to relitigate the issues of timeliness and "good cause" concerning claimant's hearing request. In reaching this conclusion, we note that, since this order neither finally disposes of nor allows claimant's occupational disease claim, it is not a final order. Price v. SAIF, 296 Or 311, 315 (1984); Lindamood v. SAIF, 78 Or App 15, 18 (1986); Jeanne C. Rusch, 43 Van Natta 1966 (1991). Consequently, as a result of this remand order, sole jurisdiction over this case will rest with the Hearings Division.

ORDER

The Referee's order dated February 27, 1992 is vacated. This matter is remanded to Referee Peterson for further proceedings consistent with this order.

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In the Matter of the Compensation of
**ELIZABETH E. HELLER, Claimant**
WCB Case No. 90-20434
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of those portions of Referee Borchers' order that: (1) upheld the insurer's denial of her occupational disease claims for vestibular dysfunction and/or brain stem injury, cognitive impairment and simple phobia; (2) declined to award a penalty and attorney fee for the insurer's allegedly unreasonable denials; and (3) awarded an assessed fee of $3,000 for prevailing on the compensability of her claim for a transient sinus irritation condition. In her brief, claimant: (1) argues that her claim for a transient irritation condition includes conditions of the eyes, ears, nose and throat, as well as her sinuses; and (2) requests remand for consideration of corrected evidence allegedly discovered after the record closed, or alternatively, a penalty and attorney fee for the insurer's allegedly unreasonable discovery violation. The insurer cross-requests review of that portion of the order that set aside its denial of claimant's claim for a transient sinus irritation condition. On review, the issues are remand, compensability, penalties and attorney fees, and the amount of the attorney fee assessed by the Referee. We deny claimant's motion to remand, affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

Claimant is a former senior software engineer who worked in the employer's Deschutes and Rhein buildings between April 1990 and July 1990.

In April 1990, a skybridge opened between the employer's Deschutes and Rhein buildings. Immediately thereafter, workers in both buildings began smelling a chemical or solvent odor. Soon, claimant and several coworkers began complaining of transient symptoms while at the worksite, such as

headaches, sinus irritation, teary eyes, dizziness and nausea. (See Ex. 27-1). Claimant sometimes wore a respirator at work, which improved her symptoms. (Tr. 188). At first, claimant's symptoms dissipated when she was away from the worksite. During July 1990, however, she began having symptoms when she was not at work, but was exposed to certain chemicals. (Tr. 197-201). Claimant has not worked since September 7, 1990.

HazCon, Inc., an environmental hygiene consulting firm, performed air quality tests for the employer in April 1990 and in August 1990. The insurer provided claimant with HazCon's initial reports. HazCon informed the employer of mathematical errors in those reports on or about October 17, 1990. (Tr. 485-87). The insurer did not inform claimant of the errors prior to the January 1991 hearing.

Claimant has preexisting reactive hypoglycemia, chronic fatigue (see Ex. 19-5) and sensitivity to certain drugs. She has current diagnoses of dysthemia, undifferentiated somatoform disorder, prior episodes of a major depressive disorder and borderline personality traits. Each of these conditions preexisted her employment. (See Ex. 24-11). She has also treated for post-traumatic stress syndrome, related to childhood abuse. She had preexisting symptoms of dizziness, nausea and seasickness, as well as nausea and dizziness while flying. (See Ex. 23-1).

Claimant is more vulnerable than the general population to damage to her vestibular system. (Tr. 402).

## FINDINGS OF ULTIMATE FACT

Claimant was exposed to toxic volatile organic chemicals at work between April and June 1990. This exposure was the major cause of her disability and need for treatment for transient eye, ear, nose and throat irritation. It was also the major contributing cause of her vestibular dysfunction and/or brain stem injury. The conditions arose out of and in the course of claimant's employment and were caused by substances to which she was not ordinarily subjected or exposed other than during her regular periods of employment. The conditions required medical services and resulted in disability. They are established by medical evidence supported by objective findings.

The insurer's denial of claimant's claims for transient eye, ear, nose and throat irritation, vestibular dysfunction and/or brain stem injury, impaired cognition, and simple phobia was not unreasonable.

## CONCLUSIONS OF LAW AND OPINION

### Motion to remand

Claimant requests that we consider evidence concerning the insurer's alleged failure to provide discovery, or that we remand for that purpose and for consideration of a corrected report. We treat claimant's request as a motion to remand for the taking of additional evidence. We may remand for further evidence if we determine 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 clearly be shown that the evidence sought to be considered is both material to the outcome of the case and that it 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).

Claimant argues that we should consider evidence which came to light after the hearing, or remand for its receipt into evidence, because it was unavailable at hearing due to the employer/insurer's allegedly deliberate withholding of it. We disagree.

Ms. Woodhull, a field services director for HazCon, Inc., testified at hearing that she made an arithmetic error in calculating the concentrations of various volatile organic chemicals (VOC) measured during the air quality assessment of the buildings where claimant worked. (Tr. 485-487; see Ex. 2). Woodhull testified that she divided when she should have multiplied, so that some concentrations were listed as nanograms per cubic meter rather than milligrams per cubic meter. Woodhull testified that, based on her miscalculation, the concentration of VOC present was a million times below federal safety standards. Under the the corrected calculations, on the other hand, the concentration was a thousand times below standards. (Tr. 488; see Ex. 27-8-11)). She further testified, however, that the graphs comparing the concentrations would look no different if the concentrations were correctly labeled.

Woodhull also testified that she alerted the employer's safety manager to the error on approximately October 17, 1990, and that she redid the calculations, made necessary corrections and reported them to the employer at that time. (Tr. 486). However, it is undisputed that claimant's first notice of the error was on the date of the hearing.

Because Ms. Woodhull admitted and explained her miscalculations at hearing, the disputed evidence was necessarily available at that time. Claimant's remedy was to request a continuance at hearing if she desired leave to allow her experts to reconsider their opinions in light of the new calculations. Claimant did not request a continuance, and we conclude that she has not established that the evidence she seeks to have considered at this time was "unavailable with due diligence" at the time of hearing. The motion for remand is denied.

Penalties and attorney fees for an alleged discovery violation

Claimant also seeks penalties and attorney fees for the insurer's allegedly unreasonable failure to disclose Ms. Woodhull's mathematical error prior to hearing. We agree with claimant that because she has an ongoing request for discovery, the employer/insurer had a duty to remedy the error in the information which it had provided after it was informed thereof. See OAR 438-07-015(2); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991). We conclude, however, that the penalty and fee issue is not properly before us because it was not raised in the pleadings, at hearing, or in post-hearing motions. Because the error in the report was revealed at hearing, claimant had an opportunity to request discovery and to raise the penalty/fee issue. She did not. Inasmuch as the scope of our de novo review is limited to the issues before the Referee, and the penalty and attorney fee issue was not raised before her, we decline to address the issue on review. See Eugene L. Mallory, 43 Van Natta 1317 (1991).

Compensability

The Referee held that three of the four conditions claimed by claimant are compensable, based in part on her conclusion that symptoms allegedly related to claimant's VOC exposure are not distinguishable from those of her preexisting noncompensable conditions. In reaching her conclusion, the Referee declined to defer to the the opinion of Dr. Morton, claimant's treating physician, finding that Dr. Morton based his opinion on inaccurate facts. We disagree.

Dr. Morton explained that his opinion concerning the causation of claimant's current problems was based on the following facts and reasoning: that claimant's symptoms of stuffy nose, post-nasal drip, chronic sore throat, sinus discomfort and earache initially arose at work (Tr. 387); that he doubted the accuracy of the available air quality test results, considering the effects of synergism, off-gassing, and occasional saturation of the sample medium (Tr. 390-394); that claimant was exposed to VOC which were both respiratory irritants and neurotoxins (Tr. 400); clinical findings, including dizziness and nausea; Dr. Grimm's opinion, which confirmed Dr. Morton's suspicion that claimant had abnormal vestibular functions associated with her work exposure to VOC (Tr. 400-403); the opinions of Drs. Colby and Erickson, who were unable to diagnose cognitive impairment (Tr. 403-408); and Dr. Colby's diagnosis of a phobia related to the workplace. (Tr. 410-413).

Even if we assume that Dr. Morton had inaccurate information regarding the carpet glue and HVAC setting, we find that Dr. Morton's opinion is based on accurate, rather than inaccurate, material facts. Moreover, we find no reason to discount Dr. Morton's opinion. We, therefore, rely on it. See Weiland v. SAIF, 64 Or App 810 (1983).

Between April 1990 and July 1990, claimant was exposed to toxic volatile organic chemicals (VOC) at work, which she claims caused the various conditions. She further claims that she was not ordinarily exposed to harmful substances other than during a period of regular actual employment. In short, claimant's claim is one for occupational disease. See ORS 656.802(1)(a).

In order to establish the compensability of an occupational disease under ORS 656.802(1)(a), claimant must prove that work exposures were the major contributing cause of the claimed conditions. The existence of the diseases must be established by medical evidence supported by objective findings. ORS 656.802(2).

That claimant was exposed to at least some VOC is undisputed and uncontroverted. The degree to which she was exposed, however, is in dispute and, on this record, is uncertain because of the timing of the air quality tests. As a result of delay between claimant's April 1990 exposure and the tests, the experts agree that it is probable that claimant's level of exposure between April 1990 and July 1990 were greater than the levels eventually measured in August 1990 and September 1990 because of an "off-gassing" phenomenon in the interim. (See Exs. 2-100, 22-8; Tr. 394, 397-98, 520-21, 623-24, 750). We conclude from this expert evidence that claimant was not ordinarily exposed to VOC, except at work. We, therefore, proceed to determine whether claimant has proven the requisite medical causal nexus between her conditions and her work exposure. See ORS 656.802.

The insurer asserts that medical evidence supporting claimant's claim is based solely on the temporal relationship between her exposure and the onset of her symptoms. We disagree.

The physicians in this case have relied on not only the close temporal relationship between the claimant's symptoms and her work exposure, but also their diagnostic expertise and consideration of other potential causal factors. Therefore, the temporal relationship is not the sole basis of their conclusions concerning medical causation. Neither is our holding based solely on a temporal relationship, for we have also considered the well-reasoned expert evidence in this record. See Bradshaw v. SAIF 69 Or App 587, 590 n.2; Cf. Allie v. SAIF, 79 Or App 284 (1986).

1. Transient eye, ear, nose and throat irritation

We adopt that portion of the Referee's "Conclusions of Law and Opinion" entitled "A. Sinusitis/Rhinusitis," with the following exception and supplementation.

Although claimant must prove that her work exposure was the major cause of her occupational disease, the physicians need not express their causal opinions in those specific terms. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Claimant argues that her claim for a transient irritation condition included symptoms involving her eyes, ears, nose and throat, as well as her sinuses. We agree and find those conditions to be compensable under the major causation standard. (See Exs. 1-12; 9-6).

2. Vestibular dysfunction and/or brain stem injury

Drs. Morton, Grimm and Donaldson examined claimant with regard to her symptoms of dizziness and disorientation. Each concluded that she suffered injury to her vestibular system and/or her brain stem as a result of her work exposure to VOC.

Dr. Morton is an expert in toxic exposure diagnoses. He referred claimant to Dr. Grimm concerning claimant's apparent vestibular dysfunction. (See Ex. 22-1, Tr. 256). Dr. Grimm, a neurologist, cataloged claimant's symptoms, reviewed her history and HazCon's air quality reports, and performed a battery of tests. He found numerous objective indications of damage to claimant's vestibular system. (Tr. 273-79). Based on his analysis of her history and the test results, as well as his review of pertinent literature, (see Tr. 256), Dr. Grimm concluded that the "principal source of disturbance" identified in claimant's vestibular system was her work exposure to VOC. (Ex. 22-8; Tr. 279-281). Dr. Morton concurred with Dr. Grimm's opinion. (Ex. 23-3).

Dr. Donaldson, an otolaryngologist, also examined claimant and reviewed her history. Based on this information, as well as other data, Donaldson opined:

> "[C]laimant had a reaction of her nasal mucosa to numerous fumes resulting in nasal congestion and probable eustachian tube obstruction with a result of aural, that's ear pressure.[1] The initial provoking material was encountered while in her working environment.
>
> She had toxic labyrinthitis secondary to the fumes, initially encountered while in her work environment.[2] She has some central pathology of an unidentified locus secondary to fumes initially encountered while in her work environment.[3]

> The degree of the symptoms resulting from numbers 1,2 and three [above-labeled diagnoses] are very difficult to assess in patients with her psychologic profile." (Ex. 36-10)."

Based on claimant's latent responses to audiological tests, Donaldson diagnosed central nervous, or brain stem, pathology, [see 3, supra]. (Ex.36-38). Donaldson also opined that claimant's abnormal central nervous system findings are related to her work exposure. (Ex. 36-15-16). He further explained that his diagnosis of toxic labyrinthitis was similarly based, (Ex. 36-16-18) [see 3, supra], because test results and physical findings were compatible with claimant's exposure. Dr. Donaldson acknowledged that he was unable to differentiate between the symptoms of labyrinthitis and those of somatization, (Ex. 36-20,-22), and conceded that claimant's sinus burning, plugged ears and aural pressure could have "an emotional basis," (Ex. 36-25). However, he found it "more logical" that the fumes resulted in sufficient swelling to cause a blockage. (Id.) He explained that when such a blocking occurs, "it causes air which is behind the blockage, i.e., in the sinuses or in the ear to be absorbed," causing a severe vacuum pain. (Ex. 25-26). Dr. Donaldson considered and ruled out non-work related causes of claimant's symptoms. His opinion, therefore, supports claimant's claim, as do the opinions of Drs. Grimm and Morton.

Although the medical evidence is divided concerning the location of the harm and the extent of claimant's symptoms, we conclude that claimant has proven the requisite major causal relationship between her work exposure and her vestibular dysfunction. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 298, 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991). We further find the well-reasoned opinions of Drs. Morton, Grimm and Donaldson to constitute clear and convincing evidence that claimant's work exposure to VOC caused that condition.

3. Mental disorders: cognitive impairment; phobic response

To establish a compensable occupational disease claim for a mental disorder under ORS 656.802, claimant must prove that her work exposure was the major contributing cause of the disorder. Moreover, such a claim is not compensable:

> "(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).

Claimant contends that she suffers from impaired cognition and a simple phobia as a result of her work exposure. The insurer responds that the claimed mental disorders preexisted her employment and are not caused, in major part, by her employment exposure. We agree with the insurer.

With regard to the simple phobic condition, we adopt that portion of the Referee's order entitled "D. Phobic Response," on pages 8-10 of the Opinion and Order.

With regard for the claim for cognitive problems, Dr. Morton recorded claimant's complaints that her loss of "thinking ability" was a major problem for her. He referred claimant to Faulder Colby, a clinical psychologist who specializes in neuropsychological testing, to determine whether and how much claimant's cognitive ability had changed. (Tr. 404). Colby tested claimant extensively and concluded that claimant's general mental ability was in the superior range (Ex. 19-14). He further found that her "level of intellectual functioning" was consistent with her formal education, (Ex. 19-8) and that she does not have measurable brain damage. Colby opined that claimant's visual memory and perceptual

organization problems are not of the type associated with exposure to neurotoxins. He concluded, "It seems more likely that these problems reflect either pre-morbid functioning or normal test variability." (Ex. 19-17). Dr. Erickson agreed, stating that claimant's subjective memory impairment was not accompanied by objective deficits. (Ex. 20-4). Dr. Binder also found no cognitive deficits. (Ex. 24-9). He opined that claimant's current psychological symptoms are related to preexisting psychological conditions, rather than to her work exposure to VOC. (Ex. 24-1).

Dr. Grimm is a neurological consultant who related claimant's asserted cognitive losses to her vestibular injury. (Tr. 290-92; Ex. 22-7-8). He opined that claimant's "inner ear disturbance with cognitive disorganization" is complicated by "a personality organization that may well have developed a phobic response to volatiles in the workplace[.]" (Id.) Dr. Grimm based his conclusion on claimant's subjective opinion concerning her problems, "some support" from Colby's testing, and the literature associating vestibular injury with cognitive loss.

The persuasiveness of Dr. Grimm's opinion is diminished by Colby's conclusion that claimant does not have measurable cognitive impairment. Thus, Colby's opinion does not support the existence of the claimant's claimed condition. Moreover, considering Colby's specialized expertise, thorough testing of claimant, and his well-reasoned opinion, as well as the supporting opinions of Drs. Erickson and Binder, we find Colby's opinion more persuasive than that of Dr. Grimm. For these reasons, as well as the reasoning of the Referee regarding claimant's phobic response claim, we conclude that claimant has not carried her burden with regard to the claimed cognitive impairment and phobic response conditions.

Unreasonable denial

Considering the conflicting medical evidence, we conclude that the insurer's denial was not unreasonable as to any of the conditions claimed by claimant, except her transient irritation. For that condition, we find that he insurer had no legitimate doubt regarding compensability. Its denial in that regard was, therefore, unreasonable. A penalty will be assessed.

Attorney fees

The insurer objects to claimant's attorney's request for an extraordinary attorney fee. In particular, it contests the 50 percent requested in addition to the hourly rate declared in counsel's Statement of Services. Inasmuch as we have found claimant's vestibular or brain stem injury compensable and the Referee did not, we increase the attorney fee award made by the Referee.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of her vestibular or brain stem injury condition and her transient eye, ear, and throat irritation conditions. 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 vestibular or brain stem injury is $12,000, 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 issues, and the value of the interest involved.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning the claim for a transient sinus irritation 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 fee for claimant's attorney's services on review concerning the compensability of her transient sinus irritation condition 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 claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 15, 1991 is affirmed in part, modified in part, and reversed in part. That portion of the order that upheld the insurer's denial of claimant's claim for a vestibular and/or brain stem injury condition is reversed. The insurer's denial is set aside and the claim is

remanded to the insurer for processing according to law. Claimant is awarded a penalty of 25 percent of unpaid amounts due as of the final date of hearing under her claim for a transient eye, ear, nose, throat and sinus irritation condition, one-half of the penalty to be paid to claimant's counsel. In addition to the assessed fee awarded by the Referee, claimant is awarded an attorney fee of $12,000, for his services at hearing and on review concerning the compensability of the vestibular and/or brain stem injury condition and the transient eye, ear and throat irritation conditions. For successfully defending against the insurer's appeal concerning the compensability of the claim for a transient sinus irritation condition, claimant is awarded an additional assessed attorney fee of $2,000, payable by the insurer. The remainder of the Referee's order is affirmed.

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February 18, 1993 Cite as 45 Van Natta 278 (1993)

In the Matter of the Compensation of
**PEGGY HOLMES, Claimant**
WCB Case No. 91-16148
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee Lipton's order that: (1) directed it to process claimant's right knee claim as a new injury rather than as an aggravation; and (2) assessed a $2,000 attorney fee. On review, the issues are claim processing and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following exceptions and supplementation.

We do not adopt the Referee's finding that claimant's accepted right knee condition completely resolved prior to its August 9, 1991 worsening. Instead, we find that claimant's accepted right knee condition remained symptomatic up to and through the August 1, 1991 incident.

In addition, although the December 12, 1991 diagnostic arthroscopy revealed degenerative arthritis, loose bodies and a partial tear of the lateral meniscus, we do not adopt the Referee's finding that the August 1, 1991 work incident was a material contributing cause of these conditions.

CONCLUSIONS OF LAW AND OPINION

The Referee directed the insurer to process claimant's claim as a new injury rather than as an aggravation. In reaching this result, the Referee relied on his belief that claimant's recently diagnosed partially torn lateral meniscus is a new condition, not a continuation of the previously accepted condition. We disagree.

Under the law in effect prior to the 1990 legislative changes, we held that, where the issue is whether claimant suffers an aggravation or new injury for the same carrier, the test for distinguishing an aggravation from a "new injury" is as follows:

> "Worsened symptoms of a compensable injury represent an aggravation * * * . A worker suffers a compensable new injury only if a subsequent incident or employment exposure independently contributes to a worsening of the prior underlying condition." Teresa L. Walker, 41 Van Natta 2283 (1989).

In effect, we adopted the standard for shifting responsibility in a subsequent employer situation for use in distinguishing between aggravations and new injuries. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). Under the Teresa L. Walker test, a claimant did not establish entitlement to compensation for a new injury -- as opposed to an aggravation-- unless she proved that her subsequent injury or work exposure independently contributed to a worsening of her prior underlying condition. See Teresa L. Walker, supra.

As of the 1990 amendments to the Workers' Compensation Law, there is a statute addressing responsibility where there was none previously. See ORS 656.308. The statute provides, in relevant part:

> "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." ORS 656.308(1).

We have interpreted the statute to require that responsibility remains with the prior employer unless it proves that claimant sustained a "new injury" or "new occupational disease" during subsequent employment. See Ricardo Vasquez, 43 Van Natta 1678 (1991); Donald C. Moon, 43 Van Natta 2595 n.1 (1991). Thus, under current law, a worker suffers a "new injury" if it is shown, by medical evidence supported by objective findings, that the worker sustained subsequent disability or need for medical services, the material contributing cause of which was an injury during her later employment. See Mark N. Weidle, 43 Van Natta 855 (1991). A worker suffers a "new occupational disease" if it is shown that work activities with the later employer or insurer were the major contributing cause of an occupational disease involving the same condition which was previously accepted by the prior employer or insurer. Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991).

In the interest of consistency and in accordance with the rationale behind the adoption of the Teresa L. Walker principle, we now conform the test for distinguishing new injuries from aggravations, in cases such as this involving the same employer/insurer, with current responsibility law. Accordingly, a worker sustains a new injury only if the later injury is a material contributing cause of the claimed disability and/or need for treatment. She sustains a new occupational disease only if her later work exposure is the major contributing cause of her current condition.

Here, due to the passage of time since claimant's initial right knee injury and the number of potential causes for her current right knee problems, the causation issue is a complex medical question which must be resolved by expert evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The reasoned expert opinions concerning causation are provided by Drs. Stewart and Gordon, orthopedists. Dr. Stewart examined claimant and reviewed her history at the insurer's request. He suspected that claimant "never really did get over her first injury and then had an aggravation of her previous injury of 11-18-89 [sic], by her 8-1-91 injury [sic]." (Ex. 42-3). Stewart was unwilling to make "further specific judgments" concerning the relationship, if any, between claimant's right knee injuries, without comparing her 1989 and 1991 MRI and x-ray films. (Id). The record contains no further opinion from Stewart.

After arthroscoping claimant's right knee, Dr. Gordon, treating surgeon, reported that the procedure revealed degenerative arthritis and a partially torn lateral meniscus, as well as a loose body in the lateral joint compartment. (See Ex. 50). Gordon was "unable to tell whether the 8-09-91 injury was a new injury that dislodged a loose body or just jarred loose a previously developing loose body in her knee." (Ex. 54-5). He concluded that "this was probably an aggravation of a pre-existing injury, but I am unable to tell for sure." (Id).

Based on Gordon's opinion, we find that claimant's loose body, partially torn meniscus and degenerative changes in her right knee are not proven to result from the claimed August 1991 work incident. Although Gordon was unable to "tell for sure," his opinion, which is supported by Stewart's belief that claimant never really got over her first injury, supports a conclusion that it is more likely than not that claimant's current problems are a continuation of her prior (1989) injury-related condition. There is no expert opinion suggesting otherwise.

Consequently, claimant has failed to establish that she has sustained a new injury. Therefore, we conclude that the insurer properly accepted claimant's claim as an aggravation of her compensable condition. In light of this conclusion, we reverse the Referee's attorney fee award.

ORDER

The Referee's order dated March 10, 1992 is reversed. The insurer's partial acceptance/partial denial is reinstated and upheld. The Referee's attorney fee award is reversed.

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February 18, 1993 Cite as 45 Van Natta 280 (1993)

In the Matter of the Compensation of
**JERRY E. JOHNSON, Claimant**
WCB Case No. 91-17214
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of those portions of Referee Garaventa's order that: (1) awarded claimant 24 percent (76.8 degrees) unscheduled permanent disability for his left shoulder condition whereas an Order on Reconsideration awarded claimant 39 percent (124.8 degrees) unscheduled permanent disability; and (2) assessed a penalty pursuant to ORS 656.268(4)(g) on the ground that claimant's award on reconsideration was increased by 25 percent or more. In his respondent's brief, claimant disagrees with the amount of the penalty awarded by the Referee. On review, the issues are extent of unscheduled permanent disability and penalties. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Extent

On review, the insurer disagrees only with the Referee's assigned value for adaptability. The Referee found that, at the time of injury, claimant was performing work in the medium category. However, because claimant's doctor had restricted him from repetitive lifting overhead, the Referee concluded that claimant had a residual functional capacity to perform medium/light work. She, therefore, assigned an adaptability value of 2.

The insurer argues that the treating doctor has only suggested that claimant not lift overhead, which is distinguishable from a restriction placed on overhead lifting. The insurer contends that claimant has essentially been released to regular work. Finally, the insurer argues that, because claimant is capable of performing his job in a different manner (i.e., "underhand"), he is not precluded from regular work.

We agree that claimant has been released to regular work. The record establishes that claimant's job does not require him to lift overhead, and that his supervisor has recommended that claimant and other workers perform the job by lifting underhand. Furthermore, the Referee found that, in the past, claimant has successfully performed his job by lifting underhand. Accordingly, because we find that claimant's job can be performed by lifting underhand, rather than overhead, we conclude that claimant has been released to regular work, which is defined as "substantially the same job held at the time of injury." OAR 436-35-270(3)(c). Also see Harrison v. Taylor Lumber & Treating, 111 Or App 325 (1992). Consequently, we conclude that claimant's adaptability value is 0. OAR 436-35-310(2).

Having determined the values 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, 0, the product is 0. When that value is added to claimant's impairment value, 14, the result is 14 percent unscheduled permanent partial disability. Claimant's permanent disability under the "standards" is, therefore, 14 percent. The Referee's award of 24 percent shall be reduced to 14 percent.

Penalty

The Referee's penalty award was based upon ORS 656.268(4)(g). However, as noted by the Referee, a penalty under that statute requires that a claimant be at least 20 percent permanently disabled. Accordingly, because we have found claimant's permanent disability award to be 14 percent, we conclude that the statute does not provide a basis for a penalty. Therefore, the Referee's penalty award is reversed.

ORDER

The Referee's order dated March 19, 1992 is modified in part and reversed in part. The Referee's and Order on Reconsideration awards are reduced. Claimant's total award is 14 percent (44.8 degrees) unscheduled permanent disability for his left shoulder condition. The Referee's penalty award is reversed. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**ANTONIO R. PEREZ, Claimant**
WCB Case Nos. 90-22330 & 91-02123
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Charles Lundeen, Defense Attorney
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Liberty Northwest Insurance Company requests review of those portions of Referee Daughtry's order that: (1) set aside its denial of claimant's aggravation claim for a current L4-5 condition; and (2) upheld the SAIF Corporation's denial of claimant's new occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

We affirm and adopt the order of the Referee, with the following modifications.

The fourth sentence in the last paragraph on page four is replaced with: "These episodes and visits were accompanied by a diminished earning capacity."

We agree with the Referee's determination that claimant's current L4-5 condition is compensably related to the L5-S1 condition which Liberty Northwest accepted. Because claimant's current L4-5 condition is related to his accepted L5-S1 condition, the current claim is one "involving the same condition" which Liberty Northwest accepted. See Beverly R. Tillery, 43 Van Natta 2470 (1991). Therefore, we apply ORS 656.308(1) concerning the responsibility issue. See Ricardo Vasquez, 43 Van Natta 1678 (1991); see also Donald C. Moon, 43 Van Natta 2595 (1991). After our de novo review, we conclude that Liberty Northwest has not established that claimant's work activities during SAIF's coverage were the major cause of his current low back condition. See Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991). Consequently, it has not proven that claimant suffered a new occupational disease during SAIF's coverage and responsibility does not shift to SAIF.

Because Liberty Northwest initiated review and claimant's compensation was not reduced or disallowed, claimant's counsel is entitled to an assessed fee under ORS 656.382(2), payable by Liberty Northwest. 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 $100, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief).

ORDER

The Referee's order dated July 31, 1991, as republished August 27, 1991, is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $100, to be paid by Liberty Northwest Insurance Corporation.

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In the Matter of the Compensation of
**GLEN D. ROLES, Deceased**
WCB Case Nos. 88-19267, 89-06314, 89-14455, 90-02245
ORDER ON REMAND
Welch, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Roles, 111 Or App 597 (1992), rev den 314 Or 391 (1992). The court has reversed our prior orders, Glen D. Roles, 43 Van Natta 278, 379 (1991), which had held that SAIF was not required to pay temporary total disability (TTD) pursuant to an earlier referee's order because that referee's order was void for lack of jurisdiction. Although the earlier referee's decision may have been erroneous, the court reasoned that such an error would not deprive the referee of subject matter jurisdiction to award claimant TTD. Inasmuch as our decision to decline to award TTD and assess penalties and attorney fees was based on our conclusion that the earlier referee's order was void, the court has remanded for reconsideration.

The extensive procedural history of this matter is fully detailed in the court's opinion, as well as our prior orders. We offer the following synopsis.[1]

Referee Michael Johnson issued an order, increasing claimant's TTD awards granted by four Determination Orders (DO). The SAIF Corporation requested Board review of Referee Johnson's order and refused to pay the TTD awarded by the order. Contending that the DOs had become final by operation of law, SAIF asserted that Referee Johnson's order was issued without jurisdiction.

Claimant requested a hearing, seeking enforcement of Referee Johnson's order. Referee Harri directed SAIF to pay the TTD awarded by Referee Johnson's order. In addition, Referee Harri assessed a 25 percent penalty under former ORS 656.262(10) based on the unpaid TTD and awarded a $3,000 attorney fee.

When SAIF continued to refuse to pay the TTD award, claimant requested another hearing. Referee Emerson assessed another 25 percent penalty based on the unpaid TTD and a $600 attorney fee.

Thereafter, another hearing regarding SAIF's continued refusal to pay the TTD award was requested. Referee Podnar dismissed claimant's hearing request, reasoning that SAIF had already been found to have unreasonably refused to pay the TTD award.

On review of Referee Johnson's order, we reversed claimant's TTD awards and reinstated the DOs. Glen D. Roles, 42 Van Natta 68 (1990). On consolidated review of the orders from Referees Harri and Emerson, we reversed the penalty assessments, but otherwise affirmed Referee Harri's conclusion that SAIF was required to pay the TTD granted by Referee Johnson's order, as well as both Referee's awards of penalty-related attorney fees. Glen D. Roles, 42 Van Natta 73 (1990).

SAIF's petition for judicial review of our "Johnson" order was subsequently dismissed. However, while that petition was still pending, claimant requested another hearing seeking SAIF's compliance with the Board's order concerning the "Harri/Emerson" orders. Referee Peterson dismissed claimant's hearing request. Reasoning that the Board's decision concerning the "Johnson" order (that reversed the TTD award) was inconsistent with the Board's decision regarding the "Harri" order (that affirmed the Referee's directive to pay the TTD award), Referee Peterson concluded that SAIF's conduct had not been unreasonable.

Before the court could proceed on SAIF's and claimant's petitions for review of our "Harri/Emerson" consolidated order, we withdrew the order for reconsideration. Reasoning that Referee Johnson's order was void and unenforceable, we concluded that the enforcement order by Referee Harri was likewise invalid. Consequently, we reversed Referee Harri's directive to pay the TTD, as well as both Referee's penalty-related attorney fee awards. Glen D. Roles, 43 Van Natta 379 (1991).

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[1] During the pendency of this appeal, Mr. Roles has died. Counsel has provided documentation confirming that fact, as well as counsel's legal representation of the decedent's surviving spouse as beneficiary for the deceased worker. For purposes of consistency, we shall continue to refer to "claimant" in this order, although we recognize that in actuality Mrs. Roles' status is as beneficiary for the decedent.

In conjunction with this reconsideration order, we issued a consolidated order on review of Referees Podnar and Peterson's orders. Glen D. Roles, 43 Van Natta 278 (1992). Reinstating claimant's hearing requests, we held that SAIF's failure to pay the TTD award was not unreasonable. Therefore, we declined to assess penalties and attorney fees.

On review of our orders, the court has concluded that Referee Johnson had authority to decide the disputed TTD issue. SAIF v. Roles, supra. Although Referee Johnson may have been in error in exercising that authority, the court reasoned that such an erroneous exercise of authority did not deprive him of subject matter jurisdiction. Since our decision was premised on the conclusion that Referee Johnson's order was void, the court has remanded for reconsideration to determine whether claimant is entitled to the TTD pursuant to former ORS 656.313(1) pending SAIF's appeal, as well as penalties and attorney fees. We now proceed with our reconsideration.

In resolving the question of whether SAIF was required to pay the TTD granted by Referee Johnson's order pending Board review, we find guidance in a recent decision from the Court of Appeals.[2]

In Roseburg Forest Products v. McDonald, 116 Or App 448 (1992), the court affirmed a Board order that had assessed penalties and attorney fees under former ORS 656.262(10) and 656.382(1) for a carrier's failure to pay TTD pursuant to a DO and an earlier referee's order. In closing claimant's aggravation claim, the DO had awarded claimant TTD. The carrier refused to pay the TTD, contending that claimant had withdrawn from the work force. Both parties requested a hearing. Although the earlier referee found that claimant was not substantively entitled to the TTD award, the carrier was ordered to pay the award pending the appeal of the DO. When the carrier refused to comply with the first referee's order, claimant requested another hearing. The second referee assessed penalties and attorney fees for the carrier's unreasonable failure to obey the first referee's order. The Board affirmed both referee orders and the carrier appealed the second order.

Stating that claimant did not have a substantive right to the TTD, the carrier contended that the TTD could not be "compensation" for the purposes of former ORS 656.313 and there could be no assessment of penalties and attorney fees for its failure to pay the TTD. The court disagreed, reasoning that the TTD was granted by a DO and required to be paid pending an appeal. Citing Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the court concluded that, regardless of whether a claim is ultimately found to be compensable, if a claimant is awarded compensation by a DO, payment "must continue until a referee or appellate body orders otherwise." Finally, the court disagreed with the carrier's characterization of the DO as "void." Although the DO might have been erroneous, the court agreed with the Board's explanation that the DO was not void.

SAIF seeks to distinguish McDonald, arguing that in this case Referee Johnson violated his statutory authority by attempting to alter DOs which had become final by operation of law. Contending that awards granted as a result of such statutorily erroneous orders do not constitute compensation, SAIF asserts that it was not obligated to pay the TTD award pending its appeal.

We are not persuaded by SAIF's attempt to distinguish this case from McDonald. In essence, SAIF's position is merely a variation on the "void" theory unsuccessfully advanced by the carrier in McDonald and SAIF's own "subject matter jurisdiction" argument which has been previously rejected by the court. Like the DO award in McDonald, Referee Johnson's TTD award has subsequently been found to be erroneous. Nevertheless, as reasoned by the Roles court, although Referee Johnson may have

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[2] Parenthetically, we note that claimant has requested oral argument. We ordinarily do not entertain oral argument. OAR 438-11-015(2). Here, through their extensive appellate briefs and supplemental written arguments on remand, the parties have availed themselves of the opportunity to fully address the impact of the relevant court and Board decisions on the issues for our determination. Inasmuch as the parties' respective positions regarding these issues have been thoroughly defined, we are unpersuaded that oral argument would appreciably assist us in reaching our decision. Consequently, we decline to grant claimant's request. Secondly, claimant has asked for the appointment of a mediator to assist the parties in resolving their disputes. SAIF is opposed to such an action. Assuming without deciding that we were authorized to grant claimant's request, we have serious reservations as to whether mediation would efficiently and effectively advance the likelihood of a satisfactory resolution of this dispute, particularly in light of one party's opposition to the request. Accordingly, this request is likewise denied.

erroneously exercised his authority in denying SAIF's motion to dismiss claimant's hearing request, the Referee's erroneous exercise of that authority did not deprive him of subject matter jurisdiction. Thus, as determined by the McDonald court regarding a DO award, the Referee's TTD award is "compensation," the payment of which must continue under former ORS 656.313 until a higher forum holds otherwise. Consequently, consistent with the rationale expressed in McDonald, we conclude that SAIF was required to pay the TTD granted by Referee Johnson's order pending its appeal.

SAIF contends that we are without authority to direct it to pay this TTD. Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), SAIF argues that claimant is not entitled to the award because Referee Johnson's order has been subsequently reversed. We find Seiber distinguishable.

In Seiber, on review of a DO, we had concluded that a carrier terminated claimant's TTD prematurely under former ORS 656.268. Although claimant was not substantively entitled to the TTD, we directed the carrier to pay this "procedural" TTD and authorized the carrier to recover this overpayment against future permanent disability awards. The court reversed, reasoning that if a processing delay does not result in an overpayment, the Board lacks authority to impose one.

Here, the TTD awarded by Referee Johnson's order is not procedural in nature. Rather, as explained in McDonald, it represents compensation to which claimant was entitled under former ORS 656.313(1) pending SAIF's appeal of Referee Johnson's order. The fact that Referee Johnson's TTD award was eventually reversed on appeal does not alter this conclusion. ORS 656.313(2) provides that, if an award is subsequently disallowed or reduced, claimant is not obligated to repay any compensation which was paid pending appeal. Thus, rather than creating an "administrative overpayment" as was disapproved in Seiber, we are simply requiring SAIF to comply with its statutory obligation under former ORS 656.313 to pay compensation awarded by an appealed Referee's order.

Accordingly, we affirm those portions of the orders from Referees Harri and Emerson that directed SAIF to pay the TTD award granted under Referee Johnson's order. Furthermore, we modify the orders of Referees Podnar and Peterson to make them consistent with this directive. In so doing, we wish to make clear that SAIF is not being required to pay the TTD award four separate times. Rather, it is being directed by four separate referee orders (as affirmed and modified by this order) to pay the TTD award granted by Referee Johnson's order.

In the event that we directed it to pay the disputed TTD award, SAIF seeks authorization to recover this "overpayment" against claimant's future permanent disability awards. Yet, were we to grant SAIF's request, we would, in effect, be permitting SAIF to recover compensation from claimant which should have been paid pending review. Such an authorization would be contrary to the principle expressed by ORS 656.313(2) that the claimant should not be obligated to repay any such compensation which was paid pending review or appeal. See Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 rev den 297 Or 340 (1984). In light of such circumstances, we decline SAIF's request for offset authorization.

Relying on the arguments presented at the various appellate levels, SAIF contends that it had a legitimate doubt regarding its liability for the TTD awarded by Referee Johnson's order. Consequently, SAIF asserts that its failure to comply with the Referee Johnson's order, as well as subsequent Referee orders, was not unreasonable. We disagree.

The fact that an issue has been extensively litigated does not preclude us from a finding that SAIF's conduct was unreasonable. The question is not whether SAIF had a legitimate doubt as to whether Referee Johnson's TTD award was erroneous. Rather, the question is whether SAIF had a legitimate doubt as to whether it was required to pay that award pending its appeal of the Referee's order. To that question, we believe there can be only one answer; no.

In essence, SAIF is contending that Referee Johnson's order was so erroneous that it was not unreasonable for SAIF to refuse to comply with it. Yet, there is no exception to the requirement in former ORS 656.313 that a request for review of a referee's order shall not stay the payment of compensation. SAIF apparently recognized this statutory obligation when it unsuccessfully sought immediate abatement of Referee Johnson's order pending its appeal. In any event, we decline to provide sanctuary for conduct which essentially defies the clear directive of a Referee order (as reiterated

by other Referee and Board orders) in contravention of a statutory requirement. To do otherwise, would be to overlook noncompliance with Referee orders, which is contrary to an underlying principle in our system. See Theodore W. Lincicum, 40 Van Natta 1953 (1988), aff'd mem Astoria Oil Service v. Lincicum, 100 Or App 100 (1990); Oscar L. Drew, 38 Van Natta 934, 936 (1986).

Consequently, we find that SAIF's conduct in failing to comply with Referee Johnson's order (as well as the subsequent enforcement order from Referee Harri and our first order) was unreasonable. Therefore, we assess a penalty equal to 25 percent of the unpaid TTD award for each act of unreasonable conduct. In other words, SAIF is assessed the aforementioned penalty four (4) separate times.

Accordingly, the penalty assessments from the orders issued by Referees Harri and Emerson are affirmed. The orders from Referees Podnar and Peterson are reversed in that (for each order) SAIF is assessed a penalty equal to 25 percent of the TTD awarded by Referee Johnson's order.

Finally, we turn to a determination of claimant's attorney fee awards for these proceedings.

We begin with the proceedings involving Referee Harri's order. Referee Harri awarded a "penalty-related" attorney fee under ORS 656.382(1) of $3,000. Claimant raised no objection to that award on Board review. In our first order on review, we affirmed that attorney fee award and awarded a $500 attorney fee under ORS 656.382(2) for claimant's defense of the TTD award. No objection to the amount of the Board's attorney fee award was registered by claimant.

Under such circumstances, we reinstate the aforementioned attorney fee awards, which we find to be reasonable. See OAR 438-15-010(4). Claimant is also entitled to an attorney fee award for finally prevailing after remand "in respect to any claim or award for compensation." ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). However, since penalties and attorney fees do not constitute "compensation," this award is confined to services rendered with respect to the enforcement of the TTD award. See Juan A. Garcia, 43 Van Natta 2813 (1991), aff'd mem Garcia v. SAIF, 115 Or App 757 (1992); Cleo I. Beswick, supra, 43 Van Natta at page 877.

Claimant has submitted a "Combined Statement of Services" detailing his counsel's efforts before the appellate courts, as well as services performed in preparing claimant's opening supplemental brief on remand. He has also requested an additional fee for services performed on remand in presenting a supplemental reply brief. The "Combined Statement" for services before the appellate courts totals approximately 52 hours. After review of claimant's appellate briefs, we conclude that roughly one-third of the efforts expended were devoted to the issues of penalties and attorney fees. Consequently, approximately 17 hours of the 52 hours involved penalties and attorney fees, with the remaining 35 hours pertaining to the TTD award.

Claimant's attorney submitted, without objection, an hourly fee for services before the court of $200 per hour. Multiplying 35 hours by the aforementioned hourly rate, we hold that $7,000 is a reasonable attorney fee for claimant's counsel's services at the court level regarding the TTD award. We have also made this determination after considering the factors set forth in OAR 438-15-010(4).

Claimant has also submitted supplemental briefs to assist in our reconsideration on remand. After reviewing his supplemental briefs on remand, we conclude that roughly two-thirds of the services were devoted to the TTD award. Since the "Combined Statement" details approximately 10 hours for services regarding the opening supplemental brief, we further hold that 6.7 hours (rounded to 7 hours) were devoted to the TTD award. Pursuant to claimant's unrebutted statement in his supplemental reply brief, an additional 7 hours were expended (excluding time on attorney fee issues). Our review of his supplemental reply also establishes that approximately two-thirds of claimant's counsel's services concerned the TTD award. Therefore, we conclude that an additional 5 hours were devoted to the TTD award. (7 / 5 = 2.33 * 2 = 4.66; rounded to 5).

Claimant's unobjected hourly fee for services at the Board level is $125. In light of these calculations and after consideration of the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for services on remand concerning the TTD award issue is $2,500. (12 * $125 = $2,500).

In conclusion, we find that, for the reasons detailed above, claimant is entitled to the following insurer-paid attorney fees resulting from Referee Harri's order: (1) $3,000; (2) $500; (3) $7,000; and (4) $2,500. In reaching this conclusion, we note that Referee Harri's order was the only Referee's order which involved the enforcement of claimant's TTD award. Consequently, we have attributed all of claimant's counsel's efforts before the Board and appellate courts regarding the TTD issue to this case.

As with Referee Harri's order, Referee Emerson's "penalty-related" attorney fee award was not contested until submission of claimant's supplemental brief on remand. Under such circumstances and after consideration of the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for services at hearing concerning the TTD issue is $600, to be paid by SAIF.

However, unlike the hearing before Referee Harri, the issues before Referee Emerson were confined to penalties and attorney fees. Claimant neither requested enforcement of Referee Johnson's TTD award nor did Referee Emerson direct SAIF to pay the award. In light of such circumstances, claimant is not entitled to an attorney fee award for finally prevailing after remand because penalties and attorney fees are not considered compensation for purposes of ORS 656.388(1). See Ernest C. Richter, 44 Van Natta 101, on recon 44 Van Natta 118 (1992); Juan A. Garcia, supra; Cleo I. Beswick, supra. Thus, claimant's attorney fee award is confined to the "penalty-related" award for services at the hearing level.

Claimant is also seeking an attorney fee for services on Board review for ultimately defending Referee Emerson's penalty and attorney fee award. Based on the foregoing reasoning, we find that there is no entitlement to an attorney fee award for such services. Furthermore, since penalties and attorney fees are also not considered compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for defending the Referee's penalty and attorney fee assessments. State of Oregon v. Hendershott, 108 Or App 584 (1991); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

As with the hearing before Referee Emerson, the proceeding involving Referee Podnar pertained to the issues of penalties and attorney fees. Claimant did not seek enforcement of Referee Johnson's TTD award. Consequently, for the reasons previously expressed, claimant's attorney fee is limited to a "penalty-related" award for services at the hearing level. Claimant's request for a $750 attorney fee for such services is uncontested. After consideration of the factors set forth in OAR 438-15-010(4), we find such a fee to be reasonable.

The proceeding involving Referee Peterson also solely pertained to the issues of penalties and attorney fees. (SAIF's failure to pay the TTD award as enforced by Referee Harri's order and affirmed by the Board's January 10, 1990 order). Based on the foregoing reasoning, claimant's attorney fee is limited to a "penalty-related" award for services at the hearing level. Claimant's request for a $937.50 attorney fee for such services is uncontested. After consideration of the factors set forth in OAR 438-15-010(4), we find such a fee to be reasonable.

Accordingly, on further consideration of the orders issued by Referees Harri, Emerson, Podnar, and Peterson, we make the following decisions.

Referee Harri's order dated February 27, 1989, as reconsidered March 16, 1989, is affirmed. For finally prevailing after remand concerning the TTD award issue, claimant's attorney is awarded $10,000 ($500 + $7,000 + $2,500), in addition to the $3,000 attorney fee granted by the Referee. As with the Referee's attorney fee award, this fee shall be paid by SAIF.

Referee Emerson's order dated May 16, 1989 is affirmed.

Referee Podnar's order dated September 13, 1989 is reversed. Claimant's hearing request is reinstated. SAIF is directed to pay claimant a penalty equal to 25 percent of the TTD award granted by Referee Johnson's order. Claimant's attorney is awarded a "penalty-related" fee under former ORS 656.262(10) and 656.382(1) of $750, to be paid by SAIF.

Referee Peterson's order dated March 16, 1990 is reversed. Claimant's hearing request is reinstated. SAIF is directed to pay claimant a penalty equal to 25 percent of the TTD award granted by Referee Harri's order as affirmed by the Board's January 10, 1990 order. Claimant's attorney is awarded a "penalty-related" fee under former ORS 656.262(10) and 656.382(1) of $937.50, to be paid by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
**GLEN D. ROLES, Deceased**
WCB Case No. 90-18683
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) found that claimant was not entitled to temporary disability pursuant to prior litigation orders; and (2) declined to assess penalties and attorney fees for the SAIF Corporation's allegedly unreasonable failure to pay the aforementioned temporary disability. On review, the issues are temporary disability, penalties, and attorney fees.

This case has been reviewed in tandem with our reconsideration of other orders involving these parties. This reconsideration was conducted in accordance with the court's instructions in SAIF v. Roles, 111 Or App 597 (1992). The procedural history of this dispute is set forth in the court's opinion, as well as our order on remand issued in this date. Glen D. Roles, 45 Van Natta 282 (1993).

For the reasons set forth in our remand order, we conclude that SAIF was required to pay the temporary disability award granted by Referee Michael V. Johnson's order. Consequently, that portion of the Referee's order which found that claimant was not entitled to the temporary disability award is reversed. Nevertheless, as stated in our remand order, claimant is only entitled to one payment of the temporary disability award granted by Referee Michael V. Johnson's order. In this respect, this Referee's order is being altered to enforce the previous directives to pay the temporary disability award.

Based on the reasoning expressed in our remand order, we further hold that SAIF's conduct in failing to pay the temporary disability award granted by Referee Michael V. Johnson's order (and the subsequent litigation orders enforcing that order) was unreasonable. Consequently, we assess a penalty equal to 25 percent of the unpaid temporary disability award.

Finally, since claimant's hearing request was filed in September 1990, amended ORS 656.262(10) is applicable. Or Laws 1990 (Spec Sess), ch 2, Section 54(2). Therefore, in lieu of a separate attorney fee award under ORS 656.382(1), claimant's attorney shall be paid one-half of the penalty assessed by this order. Amended ORS 656.262(10); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

ORDER

The Referee's order dated March 12, 1991 is reversed. Subject to the clarification expressed above, the SAIF Corporation is directed to pay the temporary disability award as granted by the prior litigation orders. Claimant is awarded a penalty equal to 25 percent of the withheld temporary disability award, to be paid by SAIF in equal shares to claimant and his attorney.

In the Matter of the Compensation of
**JERRY P. SHULTZ, Claimant**
WCB Case No. 91-02849
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of that portion of Referee Michael V. Johnson's order that awarded permanent total disability, whereas a Determination Order awarded 42 percent (63 degrees) scheduled permanent disability for loss of use or function of claimant's right leg. On review, the issues are permanent total disability and, alternatively, scheduled permanent disability.

We affirm and adopt the order of the Referee, with the following supplementation.

In evaluating permanent total disability, we consider the worker's preexisting disabilities, as well as the extent to which they were worsened by the compensable injury. Searles v. Johnston Cement, 101 Or App 589 (1990). In addition, we consider the effect of any preexisting noncompensable condition that prevents or slows the worker's recovery from the work injury. Waremart, Inc. v. White, 85 Or App 122 (1987).

The present employer cites Nelson v. EBI, 296 Or 246 (1984), for the proposition that any effects of claimant's failure to lose weight and, thereby, mitigate the effects of his injury, cannot be considered when determining the extent of his disability. We find Nelson distinguishable from the present case.

In Nelson, the Court held that when an employer proves that a worker has unreasonably failed to mitigate the effects of the compensable injury, such failure may be considered when determining the extent of the worker's disability. The Court then found that the claimant's failure to lose weight was attributable to a loss of enthusiasm for the weight loss regimen prescribed by her doctor. The Court, therefore, found that the claimant's award of disability should be reduced based on her unreasonable failure to mitigate damages.

In the present case, several doctors recommended that claimant lose weight. Unlike the claimant in Nelson, however, the present claimant has never refused to follow a weight loss program, for none has been offered. See Lee v. Freightliner Corp., 77 Or App 238 (1986); Christenson v. Argonaut Ins. Co., 72 Or App 110 (1985); Paul H. Krauche, 40 Van Natta 932, 934 (1988). In fact, Dr. Perry opined that it would be nearly impossible for claimant to lose weight because of the chronicity of his obesity. Under these circumstances, we conclude that Nelson does not control. Claimant's obesity does not preclude a finding that he is permanently and totally disabled.

In addition, the employer requests that if permanent total disability is awarded, we should authorize an offset of Social Security payments claimant has received from that award. However, we are without authority to allow the requested offset, for no reduction of permanent total disability benefits can be made unless authorized by the Department pursuant to ORS 656.209.

Inasmuch as the employer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable 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 attorney fee for claimant's counsel's services on Board review is $1,500. 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 March 19, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
**BETTY S. TEE, Claimant**
WCB Case No. 88-11538
ORDER ON REMAND (REMANDING)
Pozzi, et al., Claimant Attorneys
Mitchell, et al., Claimant Attorneys

This matter is before the Board on remand from the Supreme Court. Tee v. Albertsons Inc., 314 Or 633 (1992). The Supreme Court modified the Court of Appeals decision, 107 Or App 638 (1991), which had affirmed our order, 42 Van Natta 540 (1990), that declined to grant claimant permanent total disability (PTD) because she could perform a telemarketing job and a hotel/motel inspectress job. The Court of Appeals had held that a worker who is capable of regularly performing any service for which there exists a hypothetically normal labor market can be gainfully employed and, thus, is not PTD under ORS 656.206(1)(a).

Identifying the salient issue as the definition of the term "gainful occupation," the Supreme Court reasoned that the term relates to the earnings a worker can obtain by working at a "suitable occupation." Thus, the Court has held that the term means "profitable remuneration." Inasmuch as we did not have the benefit of its opinion in determining whether claimant's part-time employment was for profitable remuneration and since we are the appropriate body to perform the fact-finding function, the Supreme Court has remanded for further consideration concerning whether "both the telemarketing job and the hotel/motel room inspectress jobs were gainful and suitable employments for claimant."

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). 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 clearly be 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. Olson, 37 Van Natta 1054 (1986), aff'd mem, 80 Or App 152 (1986).

Here, as noted by the Supreme Court, our finding that the aforementioned part-time jobs constituted gainful and suitable employments was rendered without benefit of the Court's definition of "gainful occupation" under ORS 656.206(1)(a) as "profitable remuneration." Likewise, our previous finding was based on a record which was developed prior to the Court's defining of this important statutory term. Consequently, the record concerning whether the jobs in question represent employments for "profitable remuneration" is inadequate.[1] Finally, in light of the Court's only recent pronouncement, it is understandable that the parties would not have been prepared to present evidence on this question.

We conclude that the current record regarding this "profitable remuneration" issue is incompletely and insufficiently developed. Moreover, based on the foregoing reasoning, we are persuaded that evidence concerning this issue was unobtainable with the exercise of due diligence at the time of hearing. Consequently, under these particular circumstances (where claimant's entitlement to PTD depends on whether the part-time jobs constitute a "gainful occupation" under ORS 656.206(1)(a)), we find that there is a compelling reason to remand for the submission of additional evidence on this issue.

Accordingly, we remand this case to Referee Hoguet with instructions to admit further evidence bearing on the issue of whether the telemarketing and hotel/motel inspectress jobs constitute employments for profitable remuneration. The Referee shall conduct further proceedings to admit this evidence in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] Essentially, the record on this issue consists of testimony from two vocational counselors that a telemarketing job pays from $4 to $5.10 per hour and an inspectress job pays $4 per hour. (Tr. 76, 79, & 88). Although such evidence establishes the projected income from the employments, the record is lacking regarding the financial expenditures (if any) that claimant would realize were she to accept such employment. (For example, transportation costs, supplies / uniform expenses, child / dependent care costs, etc.)]

In the Matter of the Compensation of
**CAROLE A. VANLANEN, Claimant**
WCB Case No. 92-02682
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that assessed a penalty for its allegedly unreasonable failure to timely pay temporary disability benefits. On review, the issue is whether the Referee properly assessed a penalty. We affirm.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAIF's payment of temporary disability benefits was untimely because it was not paid within 14 days of a Board order, as required by OAR 436-60-150(4)(f). She therefore assessed a penalty for SAIF's unreasonable conduct. We agree that a penalty should be assessed, but we do so for the following reasons.

In Walden J. Beebe, 43 Van Natta 2430 (1991), we held that the filing of a request for review of a Referee's order by a carrier within 30 days stays the payment of compensation appealed without any limitation or exception as to when, within the 30 day period, the carrier's appeal is filed. ORS 656.313(1)(a)(A). Accordingly, in the present case, the Board's order, which authorized temporary disability, did not become final for purposes of ORS 656.313 until February 29, 1992, with February 28, 1992 having been the last day upon which SAIF could have appealed the order to the court.

Notwithstanding our agreement with SAIF that it did not have to pay temporary disability benefits during that time period, we find SAIF's subsequent refusal to pay such benefits until five additional days had passed to be unreasonable. Although it was SAIF's prerogative to wait until the 30th day to decide that it was not going to appeal the matter, we conclude that it was incumbent upon SAIF to promptly pay claimant the ordered temporary disability benefits once the appeal period had passed, and in this case, SAIF failed to do so.

Under the circumstances, we agree with the Referee that a penalty for the unreasonably late payment of temporary disability benefits is proper. We, therefore, affirm the Referee on the penalty issue.

Although claimant submitted a brief on review, there is no attorney fee available for claimant's counsel's services on review where the sole issue is entitlement to a penalty. See Saxton v. SAIF, 80 Or App 631 (1986).

## ORDER

The Referee's order dated June 18, 1992 is affirmed.

In the Matter of the Compensation of
**BARBARA J. CLANTON, Claimant**
WCB Case No. 91-10945
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Leahy's order that: (1) declined to remand this claim to the Workers' Compensation Division (WCD) Appellate Unit to determine whether claimant is entitled to a special temporary rule under ORS 656.726(3)(f)(C); (2) declined to increase claimant's scheduled permanent disability award of 7 percent (10.5 degrees) for the loss of use and function of the right leg, as awarded by an Order on Reconsideration; and (3) declined to increase claimant's unscheduled permanent disability of 6 percent (19.2 degrees) for a neck and shoulder injury, as awarded by an Order on Reconsideration. On review, the issues are remand and extent of scheduled and unscheduled permanent disability. We affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the fourth sentence in the fifth full paragraph on page 2 and with the following correction and supplementation. No left knee impairment was found.

In her Request for Reconsideration, claimant did not object to the impairment findings by the attending physician at the time of claim closure. (Ex. 41-1).

In her Request for Reconsideration, claimant requested adoption of special temporary rules by the Director under ORS 656.726(3)(f)(C) to accommodate her impairment for: (1) a meniscal cartilage tear in her left knee; (2) weak ankles which make walking difficult, especially up and down stairs; and (3) limited use of her arms and shoulder as a result of her dislocated left shoulder. (Ex. 41-3).

## FINDINGS OF ULTIMATE FACT

Claimant returned to modified work. Claimant experienced a 14 percent loss of earning capacity due to the compensable injury and a 7 percent loss of the use and function of the right leg (knee).

## CONCLUSIONS OF LAW AND OPINION

Claimant experienced two injuries with the same employer, one in 1989 involving the low back (WCB Case No. 91-10414), and the other in 1990 involving the left shoulder, both knees, upper back, left ankle and right foot. The 1990 claim is the subject of this review. As a preliminary matter, we note that claimant has submitted a copy of the same brief for each claim and has requested that we consolidate these cases on review. We decline to do so, for the reasons set forth in our Order on Review in WCB Case No. 91-10414, which issued this date.

Claimant also contends on review that the temporary rules used to evaluate her condition are invalid. We have held that the Board lacks authority to invalidate a rule promulgated by the Director. Eileen N. Ferguson, 44 Van Natta 1811 (1992).

### Remand

Claimant requested remand for adoption of a special temporary rule by the Director under ORS 656.726(3)(f)(C) for a meniscal cartilage tear in her left knee, for weak ankles, and for limited use of her arms and shoulder as a result of her dislocated left shoulder. The Referee declined to remand on the basis that the objective medical evidence did not establish that a special standard could be medically supported. We affirm, based on the following reasoning.

Subsequent to the Referee's order, we concluded that the Board (and thereby the Hearings Division) lacks authority to remand to the Director for a finding that a claimant's disability is not addressed by the standards and for adoption of temporary rules to accommodate such an impairment. See Gary D. Gallino, 44 Van Natta 2506 (1992).

Extent

Claimant contends, first, that she has impairment due to both her low back injury (WCB Case No. 91-10414) and this subsequent, more extensive 1990 injury that resulted in a restriction to modified work. Consequently, she argues, she is entitled to additional scheduled and unscheduled permanent disability compensation. Here, we address only the 1990 injury.

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). ORS 656.283(7) provides that the evaluation of the worker's disability shall be as of the date of issuance of the Reconsideration Order.

In those cases in which the worker became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Notice of Closure or Determination Order control. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003 and former OAR 436-35-003. In this case, the applicable rules are those that were in effect on January 22, 1991, the date the Determination Order issued.

Impairment

Medical findings which may be utilized to determine impairment under the standards are those made, or expressly adopted, by the attending physician at the time of claim closure or by a medical arbiter or panel. ORS 656.245(3)(b)(B); Dennis E. Conner, 43 Van Natta 2799 (1992). Claimant did not object to the impairment findings in her request for reconsideration; thus, no medical arbiter or panel's report was sought. On November 7, 1990, claimant was independently examined by Drs. Watson, Laycoe and Ramsthel. (Exs. 33 and 36). Dr. Breen, claimant's attending physician, concurred in their opinions. (Ex. 34). We, therefore, rely on the findings of the medical examiners as adopted by claimant's attending physician.

Scheduled Permanent Disability

Former OAR 436-35-010 through 436-35-260, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's scheduled permanent disability. WCD Admin. Orders 6-1988, 15-1990 and 20-1990.

Claimant contends that she is entitled to the scheduled disability award as requested in her request for reconsideration. That request included 7 percent for the loss of range of motion in her left knee and 5 percent for a chronic condition for her restrictions on walking. (See Ex. 41-2).

The doctors reported the range of motion for the right knee as 130 degrees flexion. The impairment value for the loss of range of motion in the right knee is 7 percent of the right leg. OAR 436-35-220(1).

Although claimant reported pain and discomfort in her ankle and foot with protracted standing, any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. Lay testimony alone is insufficient to establish any impairment as fact. ORS 656.283(7) and 656.726(3)(f)(B). The doctors, however, did not restrict claimant's walking due to any chronic condition in either leg. See Exs. 33 and 36. Consequently, no award of scheduled disability benefits is allowed for a chronic condition. We, accordingly, conclude that claimant has a 7 percent permanent loss of the use or function of the right knee.

Unscheduled Permanent Disability

Former OAR 436-35-270 through 436-35-440, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Orders 6-1988, 15-1990 and 20-1990.

In her request for reconsideration, claimant contends that she should be allowed 2 percent for a decreased range of motion in her neck and 6 percent for decreased range of motion in her left shoulder, as well as an impairment value for loss of strength in the shoulder resulting from physical damage in the shoulder. See Exs. 41-2 and 41-3.

The doctors reported the range of motion in claimant's neck as 55 degrees flexion, 55 degrees extension, 80 degrees rotation, and 30 degrees bending. None of these measurements would allow an award for loss of range of motion in the neck. See former OAR 436-35-360(1) through (5). Consequently, no rating for the neck is appropriate.

The doctors reported the range of motion of the left shoulder as follows: 120 degrees abduction, 120 degrees flexion, 55 degrees internal rotation, and 70 degrees external rotation. Based on the standards, the resulting impairment ratings are: 2 percent, 2 percent, 0 percent, and 2 percent, respectively. See former OAR 436-35-330. The doctors reported no loss of strength in the shoulder. Thus, OAR 436-35-330(19) is inapplicable. Accordingly, we affirm the Referee's opinion allowing a total of 6 percent unscheduled impairment for the left shoulder. OAR 436-35-270(1) and (2).

Claimant next contends that she returned to modified, not regular work, and thus should be allowed an award for a loss of earning capacity greater than that attributable to the impairment alone. We agree. "Modified work" means some job other than the job held at the time or injury, or the job held at the time of injury with any substantial modification of duties or the conditions under which those duties are performed. Any lifting or carrying restriction imposed by the attending physician that modifies the job-at-injury is "substantial." OAR 436-35-270(3).

Claimant's job at the time of injury was as an admitting clerk in a hospital. Her current job is as an admitting clerk in the cardiology department. Although the attending physician did not make or concur in specific lifting or carrying restrictions at the time of the closing examination, he had done so in June, 1990. These restrictions included minimal stooping, twisting, and bending; minimal pushing, pulling or lifting repetitively more than 10 pounds, minimal stairs, and minimal use of the left hand. Both he and the independent medical examiners were in agreement that claimant should not return to the job as admitting clerk in the emergency room. Claimant testified that the duties she performed at the time of injury consisted of substantially more physical activity, including frequent walking, lifting and carrying 10 to 20 pound boxes of supplies and charts, and wheeling patients in wheelchairs, than the duties of her current receptionist position, which include making appointments, answering the telephone, and sitting for the entire shift. Based on this record, we conclude that claimant returned to modified work due to her injury.

A determination of unscheduled permanent disability under the standards is made by determining the appropriate values assigned by the standards to the worker's age, education, adaptability and impairment. The education value is obtained by adding the values for formal education and skills. Under the standards applicable to this case, training is not assigned a separate value. See former OAR 436-35-300 (Temp.). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those two values is then added to the impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 57 years is 1. Former OAR 436-35-290 (Temp.).

Formal Education

The appropriate value for claimant's 12 plus years of formal education including a high school diploma is 0. Former OAR 436-35-300(3)(a) (Temp.).

Skills

Assignment of a skills value under former OAR 436-35-300(4) (Temp.) depends upon the jobs the worker performed during the 10 years preceding the "time of determination." Former OAR 436-35-300(4) (Temp.). The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (Temp.).

In this case, the "time of determination" is January 22, 1991, the date the Determination Order issued. Based upon claimant's job performance, the job title describing the job for which claimant met the highest SVP number during the 10 years prior to the time of determination was Admitting Clerk, DOT # 205.362-018. That job title is assigned an SVP number of 4. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4)(e) (Temp.).

Claimant's total education value is 3, the sum of the values for formal education and skills. Former OAR 436-35-300(5) (Temp.).

Adaptability

For workers who have been offered "modified work" or who are working at "modified work" at the "time of determination," an adaptability value is obtained from the matrix of values at former OAR 436-35-310(3)(d) (Temp.). Former OAR 436-35-310(3)(a) and (b) (Temp.). That matrix compares the physical capacity category of the worker's "regular work" with the physical capacity category of the modified work. The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (Temp.).

Here, the DOT job title most accurately reflecting claimant's regular work is Hospital Admitting Clerk. The SCODDOT identifies that job as being in the sedentary category. However, as noted above, claimant's job at the time of injury consisted of light work. The physical capacity required to perform claimant's modified work was sedentary. Therefore, the appropriate adaptability value is 2.

Calculation of Unscheduled Permanent Disability

Having determined each of the values necessary under the standards, claimant's unscheduled permanent disability may be calculated. The sum of the value (1) for claimant's age and the value (3) for claimant's education is 4. The product of that value and the value (2) for claimant's adaptability is 8. The sum of that product and the value (6) for claimant's impairment is 14. That value represents claimant's unscheduled disability. Former OAR 436-35-280.

Finally, we note that the Referee ordered this case dismissed. As neither party requested dismissal, we delete that portion of the Referee's order.

ORDER

The Referee's order dated December 17, 1991 is affirmed in part and modified in part. In lieu of the Referee's award and in addition to the 6 percent (19.2 degrees) unscheduled permanent disability benefits awarded by Order on Reconsideration, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability benefits, giving her a total unscheduled award to date of 14 percent (44.8 degrees) unscheduled permanent disability benefits for a shoulder injury. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, to be paid directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

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In the Matter of the Compensation of
**RICHARD L. OVIATT, Claimant**
WCB Case No. 88-21688
ORDER ON RECONSIDERATION
Sherwood & Coon, Claimant Attorneys
Cummins, et al., Defense Attorneys

The insurer requests reconsideration of that portion of our January 25, 1993 Order on Review which affirmed a Referee's order that awarded temporary disability benefits ("interim compensation") from July 21, 1988 through February 9, 1990. Specifically, the insurer argues that it should be entitled to terminate claimant's temporary disability benefits as of May 19, 1989, the date upon which claimant's claim was closed following the insurer's voluntary reopening of the claim for pain center treatment.

Upon reconsideration, we continue to agree with the Referee's reasoning that the insurer was not entitled to terminate claimant's interim compensation benefits until it issued its formal denial on February 9, 1990. See Roger G. Prusak, 40 Van Natta 2037 (1988). The insurer acknowledges that it did not reopen the claim on "the terms requested by claimant." We conclude that, because the purpose of interim compensation is to encourage an insurer to accept or deny a claim, see e.g., Jones v. Emanuel Hospital, 280 Or 147 (1977), the insurer's reopening of claimant's claim for other purposes did not dispose of the issue of claimant's July 1988 aggravation claim. In other words, claimant's aggravation claim was not specifically addressed until the insurer's formal denial of February 1990. Under the circumstances, we agree with the Referee's conclusion that the insurer was required to pay interim compensation until it denied that claim on February 9, 1990.

Accordingly, we withdraw our January 25, 1993 order. On reconsideration, as supplemented herein, we adhere to our January 25, 1993 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DAVID D. SHAMBERGER, Claimant**
WCB Case Nos. 90-21054, 90-15308 & 90-15745
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Charles Lundeen, Defense Attorney
Kathryn Wilske (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Mills' order that: (1) set aside its denial, on behalf of Ted Nelson, of claimant's claims for bilateral carpal tunnel syndrome and left shoulder conditions, as well as its partial denial of claimant's claim for a current right shoulder condition; and (2) upheld the SAIF Corporation's denials of the same conditions on behalf of Industrial Alloy Finishers (IAF) and Harco Manufacturing Company (Harco). In its brief, Liberty Northwest requests reimbursement from SAIF, if SAIF is responsible. On review, the issues are responsibility and reimbursement. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for his "Findings of Ultimate Fact," with the following supplementation.

Claimant worked for Ted Nelson for about two years, from May 1987 until April 1989. During that time, he was laid off twice, for about a month each time, due to lack of work. (Tr. 9). He worked for IAF from June 12, 1989 until November 1, 1989 and again from March 6, 1990 until March 23, 1990. (Tr. 55-56). He was unemployed for about three weeks in November 1989, before he started working for Harco. (Tr. 23). In March 1990, during claimant's second period of employment with IAF, he worked days at Harco and nights at IAF for about three weeks. (Tr. 54-55).

Claimant first sought medical treatment for his right wrist problems in March 1989, while employed at Ted Nelson. He first sought treatment for his left wrist and left shoulder problems on January 5, 1990, after starting work at Harco, but before beginning his second period of employment at IAF. (Tr. 57).

## FINDINGS OF ULTIMATE FACT

Claimant's current right shoulder condition is the same condition that Liberty Northwest accepted on behalf of Ted Nelson. Claimant did not suffer a new right shoulder injury or occupational disease after he stopped working for Ted Nelson.

Claimant's compensable right shoulder injury was the sole cause of his left shoulder condition.

Claimant's work at Ted Nelson could have caused his right carpal tunnel syndrome condition.

Claimant's work at Harco could have caused his left carpal tunnel syndrome condition.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

The Referee found Liberty Northwest to be responsible for claimant's bilateral shoulder and wrist conditions. We agree with regard to the bilateral shoulder and right wrist conditions, but find Harco to be responsible for the left wrist condition, based on the following reasoning.

Accepted claim: Right shoulder condition

ORS 656.308(1) provides, in relevant part:

> "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."

Under this statute, 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. SAIF v. Drews, 117 Or App 596 (1993); Ricardo Vasquez, 43 Van Natta 1678 (1991).

Thus, in this case, Ted Nelson, as the last insured against whom claimant had an accepted right shoulder injury, remains presumptively responsible. In order to avoid responsibility, Ted Nelson has the burden of establishing that claimant sustained a new compensable injury or new occupational disease involving the same condition while working for a later employer. See ORS 656.308(1); SAIF v. Drews, supra; Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991) (Section 49 ORS [656.308(1)] applies to occupational disease claims as well as to injury claims.)

Although there is some evidence that claimant's later work activities contributed to his right shoulder symptoms (see, e.g., Ex. 11-2), a preponderance of the medical evidence persuades us that claimant's current right shoulder condition is the same as the accepted condition, (see Exs. 19-1, 26). See Rodney H. Gabel, 43 Van Natta 2662 (1991) ("Same condition," under ORS 656.308(1), means identical condition.); cf. Beverly R. Tillery, 43 Van Natta 2470 (1991). There is no indication that claimant sustained a new right shoulder injury or disease after he was laid off at Ted Nelson. (See Exs. 19-1 & 26). Therefore, Liberty Northwest remains responsible for claimant's right shoulder condition.

Application of last injurious exposure rule: left shoulder and bilateral carpal tunnel conditions

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which have not been previously accepted. Fred A. Nutter, 44 Van Natta 854 (1992). Under that rule, if a worker proves that an occupational disease was caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). 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 he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986).

In order to shift responsibility to an earlier carrier, the carrier on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the prior carrier was on the risk were the sole cause or that it was impossible for work conditions during the period when the last carrier was on the risk to have caused the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 or App 370 (1984), clarified 73 Or App 223 (1985). In order to shift responsibility to a later carrier, the initially responsible carrier must show that a later employment actually contributed to a worsening of the condition. Spurlock v. International Paper Co., 89 Or App 461, 465 (1987).

In this case, it is undisputed that claimant's work for Ted Nelson, IAF and Harco involved activities which were potential causes of his current left shoulder and bilateral wrist conditions. (See exs. 11-2, 26). As of the date of hearing, claimant had not lost work time due to his compensable conditions. Therefore, we look to the date claimant first sought treatment for his left shoulder and bilateral carpal tunnel syndrome conditions, in order to assign responsibility for each. Then we consider whether the employer assigned responsibility in the first instance proves that responsibility should shift elsewhere.

Claimant complained of right hand numbness in March 1989 and Dr. Hermens, treating physician, provided a wrist splint in response to those complaints. Because claimant was laid off from his job at Ted Nelson on April 12, 1989, (Ex. A), we find that his last employer prior to seeking treatment for his right hand symptoms was Ted Nelson. Therefore, Liberty Northwest is initially assigned responsibility for claimant's right wrist condition. Progress Quarries, supra.

Claimant first sought medical treatment for his left shoulder and left hand problems on January 5, 1990. (Exs. 6-6 and 6-8). His last employer prior to seeking treatment for his left upper extremity problems was Harco. Therefore, Harco is initially assigned responsibility for these conditions.

Due to the number of potential causes in the present case, the causation issue is a complex medical question. Therefore, we rely on expert medical opinion to resolve the issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). We rely on those opinions which are well-reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Radecki states that claimant's work operating grinders for Ted Nelson was the major contributing cause of his bilateral hand and wrist conditions. (See Ex. 25). However, Dr. Hermens, attending physician, noted that claimant's work at Harco involved acute wrist flexion and opined that that job contributed to the bilateral carpal tunnel condition as well. (Ex. 19-2). Dr. Hermens also opined that claimant's left hand and wrist symptoms were "more" related to the work at Harco. (Id.). We note at the outset that a medical opinion concerning the cause of symptoms does not necessarily address the cause of the condition causing the symptoms. Moreover, Dr. Hermens' opinion in this regard was based on his recollection that claimant did not report left hand symptoms until January 1990, after commencing work at Harco. Inasmuch as claimant credibly testified that he did have left hand symptoms when he worked at Ted Nelson, but did not seek treatment for them because his right shoulder was a more immediate problem, we are not persuaded that this portion of Dr. Hermens' opinion regarding the causation of claimant's left carpal tunnel condition is based on an accurate history. Therefore, we do not rely on it. See Somers v. SAIF, supra.

On this record, we conclude that neither Harco nor Ted Nelson have carried their burdens to avoid liability under the last injurious exposure rule. Therefore, responsibility stays where it is initially assigned for the bilateral carpal tunnel syndrome, i.e., Ted Nelson remains responsible for the right and Harco remains responsible for the left.

The only medical evidence concerning the causation of claimant's left shoulder condition is Dr. Hermens' opinion that the problem is probably due to claimant's favoring his right shoulder. (See Exs. 11-2 and 19-2). In the absence of evidence associating claimant's left shoulder condition with anything other than his compensable right shoulder condition, we find that Harco has established that claimant's work for Ted Nelson, specifically the compensable injury during the earlier employment, was the sole cause of the left shoulder condition. Therefore, responsibility for the left shoulder condition lies with Ted Nelson. See FMC Corp. v. Liberty Mutual Ins. Co., supra.

Reimbursement

Inasmuch as a reimbursement dispute does not constitute a matter concerning a claim, we lack jurisdiction to resolve such a dispute. Multnomah County School District v. Tigner, 113 Or App 405, 409-10 (1992). Rather, the authority to take such action rests with the Department. Id.

Attorney fees

Claimant's wage rate was higher for Ted Nelson ($11.20 per hour) than it was for Harco ($9 per hour). Consequently, if responsibility for claimant's right carpal tunnel syndrome and shoulder conditions were reassigned to Harco, claimant's temporary disability would be reduced. Under such circumstances, claimant's attorney is entitled to an attorney fee for services on review. International Paper Co. v. Riggs, 114 Or App 197 (1992).

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 responsibility issue is $250, to be paid by Liberty Northwest. 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 14, 1990 is affirmed in part and reversed in part. Those portions of the order that set aside Liberty Northwest Insurance Corporation's denial of claimant's claim for a left carpal tunnel syndrome condition and upheld the SAIF Corporation's (Harco) denial of that condition are reversed. Liberty Northwest's denial of that condition is upheld. SAIF's (Harco) denial of the left carpal tunnel syndrome condition is set aside and the claim is remanded to SAIF (Harco) for further processing in accordance with law. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded an attorney fee of $250, to be paid by Liberty Northwest (Ted Nelson).

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In the Matter of the Compensation of
**GARRY D. SMITH, Claimant**
WCB Case No. 91-06313
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of those portions of Referee Livesley's order which: (1) awarded additional temporary total disability; (2) found claimant's temporary disability rate should be calculated on an average weekly wage of $388.99 per week; and (3) assessed a penalty for its failure to pay temporary disability benefits after September 24, 1989. On review, the issues are temporary total disability, rate of temporary total disability and penalties.

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

The employer contends that claimant was released to his regular employment by treating physician, Dr. Patterson, on February 27, 1991. Therefore, the employer asserts that claimant's temporary disability award should be terminated as of that date, pursuant to ORS 656.268(3)(a). We disagree.

On February 27, 1991, Dr. Patterson reported that claimant "was cautioned against heavy lifting of more than 30 pounds. I think it is quite clear if he were to return to either [of] his former employment that was associated with the injury that he would re-injure his back and have further back problems." (Ex. 14-2).

On this basis, we find that Dr. Patterson did not release claimant to regular work as of February 27, 1991. Rather, Dr. Patterson placed restrictions upon claimant's ability to perform his regular work. Further, even if Dr. Patterson's February 27, 1991 report were to constitute a release to modified employment, claimant's temporary total disability compensation could not be terminated on that basis; there is no evidence that such modified employment was offered in writing to claimant. See ORS 656.268(3)(c); Rocky L. Coble, 43 Van Natta 1907 (1991), aff'd Coble v. T. W. Kraus & Sons, 116 Or App 62 (1992).

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's services on Board review concerning the temporary disability issues is $750, 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 issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services rendered on review concerning 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 May 5, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750 to be paid by the employer.

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In the Matter of the Compensation of
**ANDERSON DUDLEY, Claimant**
WCB Case No. 90-05896
ORDER ON REVIEW
Jeffrey Foxx, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Brown's order that granted claimant permanent total disability, whereas a Determination Order had awarded no additional unscheduled permanent disability beyond the 35 percent (112 degrees) previously awarded for a low back condition. On review, the sole issue is permanent total disability.

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

To prove entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant 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).

We agree with the Referee's findings that it would be futile for claimant to seek employment and that, but for the compensable injury, claimant is willing to seek work.

The insurer argues that claimant's subjective estimation of his physical capacity is undermined by his actual physical activity. We disagree. Claimant testified that he was not able to perform any activity more than about two hours and that his endurance decreased as the day progressed. He testified that he did some gardening, mowed his small yard, and did some driving. However, he also testified as to how he modified these activities to accommodate his back pain. Any yard work was done in increments of about half an hour followed by lying down to rest. On long trips, his wife did most of the driving with claimant lying down on the back seat. He limited his actual driving to half an hour to an hour. This physical activity is not inconsistent with what the record shows as claimant's physical capacity.

The insurer also argues that the opinions of Drs. Roberts and Dunn are unpersuasive in that they rely on claimant's subjective report that he is unable to be active more than about two hours per day due to low back pain. We disagree.

In October 1989, claimant underwent a physical capacities evaluation (PCE). The evaluators found that claimant was capable of sedentary work and "could tolerate a 3-4 hour day given flexibility to change position as needed including a side-lying and semi-reclined position in a chair." (Ex. 52-5). They also noted that it appeared that claimant could increase his endurance to five to eight hours given motivation and pacing. Id.

Following the PCE, Dr. Roberts, claimant's treating physician, referred him to a pain management program supervised by Dr. Dunn. This program included more than two months of physical therapy. (Exs. 55, 59). Following this pain management program, claimant was released to perform an exercise program at a local health club to maintain his physical capacity. (Ex. 59-13). Through the date of the hearing, claimant consistently followed the exercise program at the health club and included stretching exercises at home.

However, Dr. Roberts noted that, in spite of this therapy, claimant had reached maximum benefit and was only able to "be up" a maximum of two hours. (Exs. 68, 70, 71). On June 20, 1991, Dr. Roberts explicitly disagreed with the October 1989 PCE estimation of claimant's capacity. (Ex. 73-3). He noted that for an extended period of time claimant "has been unable to function for longer than about two hours at a time" and opined that this seemed unlikely to change. Id.

Dr. Roberts, M.D., has served as claimant's treating physician since the initial work injury to claimant's low back in 1982. Given this long treatment history, we find that Dr. Roberts is in the best position to determine claimant's physical capacities.

The vocational evidence establishes that there is no available job market for claimant if he is unable to work more than two hours per day. Mr. McLean, vocational consultant, evaluated claimant's eligibility for vocational services. He determined that, if claimant could only work one to two hours and then must lie down, he had no transferable skills or career alternatives. (Ex. 43-7). However, Mr. McLean opined that there were jobs available for claimant if he could perform sedentary work four hours per day as estimated by the PCE. (Ex. 57-5, -6).

Mr. Green, vocational consultant, reviewed the record, met with claimant, and testified at hearing as an expert witness for claimant. (Ex. 72, Tr. 76-100). Mr. Green opined that claimant could not compete in the labor market given his ability to work only two hours a day and his need to lie down. (Ex. 72, Tr. 81, 85). Mr. Green also noted that claimant's need to side-lie and semi-recline in order to maintain the three to four hour day estimated by the PCE would eliminate his access to any part time sedentary labor market. (Tr. 82).

Given the fact that Dr. Roberts' opinions establish that claimant is unable to work more than two hours per day, we find that the vocational evidence establishes that any work search would be futile. However, we agree with the Referee that, but for his compensable injury, claimant is willing to work. Claimant credibly testified that he would like to get back to work. (Tr. 71, 72). Furthermore, claimant has made consistent efforts to increase his physical endurance and thus increase the possibility that he would be able to return to work.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 permanent total disability issue is $1,000, 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 issue, and the value of the interest involved.

ORDER

The Referee's order dated December 31, 1991 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid directly to claimant's attorney by the insurer.

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February 22, 1993 Cite as 45 Van Natta 300 (1993)

In the Matter of the Compensation of
**JAMES E. SMITH, Claimant**
WCB Case No. 92-00609
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant requests reconsideration of our December 30, 1992 Order on Review. Specifically, claimant contends that we erred in affirming an Order on Reconsideration that did not award permanent disability benefits for a right index finger injury.

On January 29, 1993, we withdrew our December 30, 1992 order for reconsideration and allowed the SAIF Corporation ten days to file a response to claimant's motion. SAIF's response has been received.

Claimant accidentally injected the tip of his right index finger with paint from a spray paint gun while working. At hearing and on review, claimant argued that he is entitled to a chronic condition impairment rating. In our December 30, 1992 order we affirmed and adopted the Referee's Order and Opinion which found that the closing report of claimant's treating surgeon, Dr. Dreyer, did not support claimant's contention that he sustained a chronic condition impairment.

In addition, we supplemented the Referee's order by finding that, even assuming that Dr. Dreyer's report constituted objective evidence of impairment, that impairment was not ratable under the applicable standards. We based this supplementation on our finding that only claimant's right index finger had been injured and the applicable standards allow for impairment for chronic condition only in specified body parts which include "hand/wrist" but do not include "finger." Former OAR 436-35-010(6). Also, we found that, even if claimant had ratable impairment in his index finger, that impairment could not be converted into a hand value and thus qualify for a chronic condition impairment because conversion to a hand value is allowed only if there is a loss of use of multiple digits. Former OAR 436-35-070(1).

On reconsideration, claimant disputes the basis of our supplementation and argues that the injury was not limited to his right index finger but extended to his right hand. However, even assuming that the injury extended to claimant's right hand, the fact remains that chronic condition impairment is established by a preponderance of medical opinion. Former OAR 436-35-010(6). We continue to adopt the Referee's reasoning and conclusions regarding his analysis of Dr. Dreyer's closing report. On this record, there is no medical evidence that claimant suffers from a chronic condition that limits repetitive use of his right hand.

Accordingly, our December 30, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 30, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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February 23, 1993 Cite as 45 Van Natta 301 (1993)

In the Matter of the Compensation of
**ELIZABETH S. FIELDS, Claimant**
WCB Case Nos. 92-07092 & 92-03748
ORDER ON REVIEW
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant, pro se, requests review of those portions of Referee Nichols' order that: (1) upheld the insurer's denial of claimant's occupational disease claim for a bilateral wrist condition; and (2) upheld the insurer's denial of claimant's cervical and right upper extremity injury claim. The insurer has cross-requested review of that portion of the Referee's order that assessed a penalty for the untimely payment of interim compensation. With her brief, claimant has submitted materials that were not presented as evidence at the time of hearing. (A picture of what is apparently her left arm and a February 27, 1992 letter from OSHA acknowledging a complaint concerning her former employer for "potential safety/health hazards"). We treat such a submission as a motion for remand to the Referee for the taking of additional evidence. ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, compensability, and interim compensation. We deny the remand motion. The Referee's order is affirmed in part and reversed in part.

We have no authority to consider evidence not already included in the record. Under ORS 656.295(5), we have authority to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, the evidence which claimant has submitted pertains to a picture which is apparently of her left arm and a February 1992 OSHA letter regarding a safety/hazard complaint against her employer. Noting that references to her left arm injury and her employer's lack of medicinal supplies were made at the hearing, claimant asks that these materials receive consideration.

We conclude that there is not a compelling reason to justify remanding this case to the Referee for the taking of further evidence. When viewed in a light most favorable to claimant, these submissions satisfy only the first criteria of the test for determining whether remand is warranted; i.e., they arguably concern disability. In any event, we are unable to find that these materials were unobtainable at the time of hearing. Finally, when considered with the record as presently developed, it cannot be said that this submission is reasonably likely to affect the outcome of this case. Consequently, the motion to remand is denied.

We affirm and adopt those portions of the Referee's order which upheld the insurer's denials of claimant's occupational disease and injury claims. We reverse that portion of the Referee's order that assessed a penalty for the insurer's failure to begin the payment of interim compensation within 14 days of its notice of the claim.

To begin, although the Referee addressed the issue of interim compensation in her order, the hearing transcript does not establish that such an issue was raised. (Tr 1 & 2). Our review of the record is confined to the issues presented at hearing. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). When an issue is not raised at hearing, that issue will not be subsequently considered on review. Mavis v. SAIF, 45 Or App 1059 (1980).

Inasmuch as claimant did not raise the issue of interim compensation at hearing, the Referee should not have addressed the issue. In any event, even if the Referee was authorized to consider the issue, we disagree with the conclusion that claimant was entitled to interim compensation.

A claimant is entitled to temporary disability (in the form of interim compensation) pending acceptance or denial of a claim for a disabling injury if she "leaves work" due to the injury. Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). If a claimant has been laid off or is not earning wages at the time of her injury, she has not demonstrated that she left work due to the injury and she is not entitled to interim compensation. Ninfa Hernandez, 44 Van Natta 2355 (1992); Donna R. Ruegg, 41 Van Natta 2207 (1989).

Here, claimant was not receiving wages from her former employer at the time of her January 1992 occupational disease claim. Rather, she had already been terminated from her employment in December 1991 for reasons unrelated to her allegedly work-related condition.

In light of such circumstances, we are unable to find that claimant "left work" as a result of an injury or a work-related condition. Thus, the insurer was under no obligation to provide interim compensation. Inasmuch as claimant was not entitled to such benefits, it follows that the insurer was not unreasonable in failing to begin the payment of this compensation within 14 days of its notice. Accordingly, the Referee's assessment of a penalty is likewise reversed.

## ORDER

The Referee's order dated September 18, 1992 is affirmed in part and reversed in part. That portion of the order which assessed a penalty (to be shared equally by claimant and her former counsel) is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**STEPHANIE L. BARNARD, Claimant**
WCB Case No. 91-14344
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Montgomery W. Cobb, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Neal's order which: (1) upheld the insurer's denial of claimant's aggravation claim for a low back strain; and (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable delay in denying claimant's claim. On review, the issues are aggravation and penalties and attorney fees.

We affirm and adopt the order of the Referee.

ORDER

The Referee's order dated January 16, 1992 is affirmed.

**Board Member Hooton dissenting.**

This case involves a claim for aggravation. Claimant experienced a compensable low back injury on December 7, 1989. She was released to her previous employment on September 8, 1990 by Dr. Nelson, an independent medical examiner. At the time of that release, Dr. Nelson noted ongoing low back pain aggravated by lifting. However, Dr. Nelson felt that claimant could successfully self-treat with pacing and exercise and that her work, which he presumed to be primarily administrative, would not interfere.

Unfortunately, upon her return to work, claimant was not able to limit herself to purely administrative duties. She also found herself working extended hours for seven days a week. During this same period, claimant stopped her exercise program, though whether as a consequence of her extended hours or simply by personal choice is not established by the record. Her symptoms increased to the point that her treating physician, Dr. Swenson, found it necessary to limit her hours of employment. Her employer, unable to accept the limitation, terminated her.

During the course of this claim, claimant has been examined by a variety of physicians, including Dr. Mandiberg, Dr. Hardiman, Dr. Nelson, Dr. Lisac, Dr. Wells and Dr. Glass. All of these physicians have related claimant's back pain to her compensable injury at one time or another and, as a group, describe claimant as a compulsive worker with difficulty in self-pacing. Dr. Mandiberg indicates that claimant has experienced low back pain from the time of the original compensable injury, which has become chronic. He also notes that she has a mild degenerative condition, though he does not discuss any causal implications of this component of claimant's diagnosis. Prior examiners, however, have given the condition very little significance. Dr. Mandiberg also acknowledged claimant's obesity and stated that it was contributory to claimant's chronic low back pain, but also asserted that weight loss would not produce a pain-free state. (Ex. 81).

Though each of the physicians who examined claimant after her worsening concluded that she, in fact, suffered from increased symptoms of low back pain, no physician was able to establish an objective (i.e., pathological and verifiable) worsened clinical condition. Even at the time of claim closure in 1990, claimant failed to demonstrate any continuing objective physical injury. The absence of strictly objective findings led to a referral to Dr. Glass for psychiatric evaluation to determine if claimant's psychological condition might explain the ongoing symptomology.

Following a thorough psychiatric examination, Dr. Glass concluded that the claimant did not suffer from a psychiatric condition or disability. He did note, however, that she has difficulties adjusting to the limitations imposed by her compensable injury. He found claimant to have been a very hard worker over time, who has never had to adjust to physical limitations or restrictions. As a consequence, claimant is incapable of pacing herself within the restrictions imposed by her physical

condition and, therefore, has become over-focused on her somatic complaints. Dr. Glass never suggested that claimant's pain complaints were less than real, or that she had completely recovered, neither is there any suggestion that claimant was using her injury to escape the stresses of her employment. (Ex. 54).

On October 11, 1991, claimant was referred to Western Medical Consultants for an independent medical examination conducted by Drs. Colletti and Wilson. They concluded that claimant had recovered from the physical effects of her accepted low back strain, a condition which they considered completely healed. That conclusion is based upon their own definition of soft tissue injury, rather than claimant's history and the extensive medical record. That "definition" would seem to suggest that no claimant could ever aggravate from a soft tissue injury.

To explain the continuation of low back symptoms, Dr. Wilson mischaracterizes the report of Dr. Glass. He argues that Dr. Glass found that claimant utilized the effects of her injury to avoid the stresses of her employment, and that she continued to do so. He concluded that there was no treatment necessary, except resumption of the exercise program. (Exs. 84 and 86).

In reviewing this evidence, the Referee made three substantial errors. First, she asserts an incorrect standard of proof. Second, her findings under that standard are not supported by the evidence. And, third, the Referee misapplies the relevant case law to conclude that there is no objective medical evidence to support a worsened condition.

Here, the Referee applies a persuasiveness standard, rather than the preponderance of the evidence standard appropriate to workers' compensation litigation. I have previously commented on the difference between persuasiveness and preponderance of the evidence in Ronald J. Trout, 45 Van Natta 322 (1993) and refer the parties to my dissent in that case on this issue.

Even if persuasiveness is synonomous with the preponderance of the evidence standard, the Referee's specific findings are not supported by the evidence. The Referee finds the report of Drs. Colletti and Wilson, combined with Dr. Wilson's deposition testimony, to be the most persuasive evidence in the record. However, the Referee does not explain the factual basis for that conclusion. In reality, Drs. Colletti and Wilson have taken the position that claimant has fully recovered from the effects of her compensable injury, a finding contrary to every other medical opinion in this record. Those opinions are numerous and substantial. It is not reasonable to conclude that Drs. Colletti and Wilson are right and every other doctor who has examined claimant, including her treating physician, are wrong. Indeed, the only reasonable conclusion in light of the great weight of contrary evidence is that claimant has not fully recovered from the consequences of her accepted low back condition, and that she, in fact, suffers from chronic low back pain as a consequence of that injury.

In support of their opinion, Drs. Colletti and Wilson purport to rely on the findings and conclusions of Dr. Glass. However, those conclusions are substantially mischaracterized in order to conform to the opinions expressed by Drs. Colletti and Wilson. As noted above, Dr. Glass never indicated that claimant did not experience real low back pain, or real limitations as a result of her compensable injury. Dr. Glass also never concluded that claimant was using the low back injury as a method of escaping the stresses of her employment. Because Drs. Colletti and Wilson base their conclusions on a mischaracterization of Dr. Glass, and on the spurious definitional assumption that claimant is completely healed of the physical effects of her compensable injury, a fact which is not supported by any other medical evidence in this record, the medical evidence provided by these physicians is remarkably unreliable and entitled to little weight. Indeed, virtually every other physician has concluded that claimant continues to experience real and chronic low back pain from the time of her compensable injury.

In Garcia v. Boise Cascade Corp., 309 Or 292 (1990), the Supreme Court noted that "[a]n assertion of a finding of fact as a part of an explanation for disregarding evidence is subject to attack if that fact relied upon is not itself supported by substantial evidence." 309 Or at 296. That same reasoning logically applies to an explanation for relying on evidence provided by a single physician or examination. The finding that Drs. Colletti and Wilson are the most persuasive of the medical experts in the present claim is not supported by substantial evidence in the record as a whole. The conclusion is wholly unsupported and should be reversed.

Finally, it appears that the Referee applied an incorrect legal analysis in the resolution of this claim. The Referee correctly stated the appropriate legal analysis when she stated that: "[c]laimant must prove by a preponderance of the evidence that since the last arrangement of compensation, she suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury and such worsening resulted in diminished earning capacity." (Opinion and Order at 2). Nevertheless, when applying the standard, the Referee found that there was no objective evidence to support claimant's pain complaints, and she relies upon the findings of Dr. Mandiberg that the injury did not clinically or objectively worsen.

In Suzanne Robertson, 43 Van Natta 1505 (1991), we concluded that a doctor's conclusion following examination that claimant actually experiences pain is objective evidence in support of pain complaints. That interpretation of the relevant standard was approved by the Court of Appeals in Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Here, virtually every physician who examined claimant, with the exception of Drs. Colletti and Wilson, concluded that she actually experienced chronic low back pain from the time of her compensable injury. Consequently, there is objective evidence to support claimant's pain complaints.

In addition, claimant is not required to show an objective or clinical worsening of her condition. The worsening may be entirely subjective, involving only an increase in pain complaints. Nevertheless, if that worsening results in increased disability, claimant has established a claim for aggravation. While the Referee acknowledged this standard, the standard actually applied requires an objective or pathological worsening separate from any increase in subjective symptomology. That misapplication of the correct rule of law is also error for which the Referee's Opinion and Order should be reversed.

For all of the above-stated reasons, I find that the Opinion and Order of the Referee is erroneous. Therefore, I respectfully dissent.

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In the Matter of the Compensation of
**BRUCE C. DARR, Claimant**
WCB Case No. 91-03885
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of that portion of Referee Howell's order which dismissed claimant's hearing request concerning a January 11, 1990 Determination Order as untimely. On review, the issue is timeliness of hearing request. We reverse and remand.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's hearing request challenging the January 11, 1990 Determination Order was untimely. Therefore, he dismissed claimant's request for hearing as to the Determination Order. We disagree.

Under former ORS 656.268(6), claimant has 180 days from the date upon which the Determination Order was "mailed" to him to request a hearing. Moreover, former ORS 656.319(4) provides that a request for a hearing concerning objections to a Determination Order shall not be granted unless a request for hearing is filed within 180 days after the Determination Order is mailed to the parties.

In interpreting an earlier version of those statutes with virtually identical language, we have previously determined that mailing of the Determination Order alone does not necessarily trigger the running of the statutory time period. Anton v. Mortensen, 40 Van Natta 1177, on recon 40 Van Natta 1702 (1988). Analogous to the Supreme Court's discussion of the issue with regard to notice of denials in Norton v. Compensation Department, 252 Or 75, 78 (1968), we have determined that mailing creates only a presumption that a claimant has received actual notice and, "if the facts rebut the presumption that mailing produces actual delivery of notice, the statutory period does not begin to run until the date of successful mailing or actual notice." Anton v. Mortensen, 40 Van Natta at 1179. Consequently, we held that if a Determination Order is not successfully mailed or actually received at a claimant's residence, the presumption of actual delivery of notice has been rebutted and it would be inappropriate to foreclose a claimant from requesting a hearing on the order, provided the request was filed within one year of the successful mailing or claimant's actual notice of the order. Id. Since Mortensen was decided, the time limit for appealing a Determination Order has been changed to 180 days. See ORS 656.268(6)(b).

Here, the evidence establishes that the Determination Order closing claimant's September 1989 low back injury claim was mailed on January 11, 1990 to claimant at his last known mailing address in Astoria. (Ex. 16A). However, pursuant to the parties' stipulation at hearing, claimant's copy was returned as undeliverable to the Evaluation Section of the Workers' Compensation Division (WCD) because claimant had moved. (Ex. 16A-3; Tr. 4). WCD sent claimant's copy to the insurer with a request to forward it to claimant's new address, if available. (Id.). The insurer received claimant's copy and WCD's request on February 23, 1990. (Id.). By that time, claimant had given the insurer his new mailing address. (Tr. 15, 18). Also, claimant's new address was on a medical report received by the insurer on February 15, 1990. (Ex. 17). The insurer did not forward his copy to him at that time nor did it tell him that his claim had been closed by a January 11, 1990 Determination Order. (Tr. 18-19). Claimant did not receive the Determination Order until the insurer successfully mailed it to his new residence on or about February 20, 1991. (Tr. 47).

On this record, we find that claimant never actually received the January 11, 1990 mailing of the Determination Order at his residence and the Determination Order was not successfully mailed until late February 1991. We, therefore, conclude that the facts in this case rebut the presumption that there was a successful mailing to claimant at his residence or that claimant actually received the January 11, 1990 Determination Order prior to February 20, 1991. Consequently, we hold that, because the statutory period did not begin to run until February 20, 1991, his April 1, 1991 hearing request was timely, as it was less than 180 days from the date of successful mailing to claimant at his actual residence (constructive notice) or actual notice. See Anton v. Mortensen, supra.

Furthermore, inasmuch as we have held that claimant's hearing request concerning the January 11, 1990 Determination Order was timely, we also find that, resolution of the other issues asserted by claimant at hearing pertaining to that Determination Order can best be achieved by introduction of additional evidence at hearing. We may remand to the Referee should we find that the record has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is appropriate here.

Accordingly, that portion of the Referee's order which dismissed claimant's hearing request from the January 11, 1990 Determination Order is vacated and this matter is remanded to the Referee to take additional evidence regarding the remaining issues. 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 considering those issues raised at hearing.

IT IS SO ORDERED.

In the Matter of the Compensation of
**GABRIELE H. FLORES-LINSNER, Claimant**
WCB Case Nos. 92-01857 & 91-18091
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Spangler's order that upheld the insurer's January 1992 denial of her occupational disease claim for a right wrist and arm condition. On review, the issues are the preclusive effect of claimant's failure to appeal an earlier denial and, if claimant is not barred from litigating her instant claim, compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Matter

On May 22, 1992, the Board issued an interim order granting the insurer's motion to dismiss claimant's request for review insofar as it pertained to the insurer's July 1991 denial (WCB Case No. 18091). The order further stated that review would be confined to claimant's hearing request regarding the insurer's January 1992 denial. We adhere to and incorporate that order into this Order on Review.

### Preclusive Effect of Previously Unappealed Denial

Claimant filed a claim in May 1991 for right wrist pain. In July 1991, the insurer denied the claim. Claimant did not appeal the denial. Claimant filed a second claim in November 1991, again for right wrist symptoms, which the insurer denied in January 1992.

The Referee first considered whether claimant's failure to appeal the first denial barred her from contesting the second denial. Finding that the case involved "new operative facts," the Referee concluded that res judicata was not applicable. However, the Referee further found that claimant had failed to prove that her condition had worsened and, therefore, she did not establish compensability. See ORS 656.802(2).

An uncontested denial bars future litigation of the denied condition unless the condition has changed and claimant presents new evidence to support the claim that could not have been presented earlier. Liberty Northwest Corp. v. Bird, 99 Or App 560, 563-64 (1989), rev den 309 Or 645 (1990). A worsening of the denied condition is considered a "changed" condition. See Kepford v. Weyerhaeuser, 77 Or App 363, 365, rev den 300 Or 722 (1986). Therefore, claimant is not barred from proving that a condition has worsened, even though that condition was the subject of an unappealed denial.

Claimant first asserts that her condition is not the same as the one that was denied in July 1991. Specifically, claimant contends "she suffered a relatively minor strain in May 1991 which healed [and was denied in July 1991], and then suffered a separate more serious injury in November of 1991, resulting in this present litigation."

Claimant's position is contrary to the record. Although claimant was diagnosed with a sprained right wrist in May and June 1991, (Exs. 3-2, 7-2), and then tendinitis in November 1991, (Ex. 13-1), her treating physician, Dr. Ushelman, occupational health specialist, indicated that he was treating the same condition as the one treated in May and June 1991. (Exs. 20-1, 22-1). That opinion was also supported by Dr. Button, hand surgeon, who conducted an independent medical examination. (Ex. 15-3). Furthermore, claimant's history to Dr. Ushelman, and her testimony at hearing, showed that her hand pain continued unabated from May 1991 through November 1991. (Ex. 13-1; Tr. 10, 13).

Although we find that claimant's condition consists of the same symptom complex, we also find that she proved that her symptoms worsened. (Tr. 10, 13). Therefore, we find that claimant proved a "worsened" condition for purposes of res judicata and that she is not precluded by the unappealed denial from litigating the instant claim. See Kepford v. Weyerhaeuser, supra. Thus, we proceed to compensability.

Compensability

Although we have found above that a symptomatic worsening is sufficient for purposes of res judicata, in order to prove compensability of her occupational disease claim, claimant must show a pathological worsening of her condition. See ORS 656.802(2). We agree with the Referee that claimant proved only that her symptoms had increased and we adopt that portion of his order. Therefore, we also conclude that claimant failed to establish compensability.

ORDER

The Referee's order dated April 13, 1992 is affirmed.

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February 24, 1993 Cite as 45 Van Natta 308 (1993)

In the Matter of the Compensation of
**RUDY HALVORSEN, Claimant**
WCB Case No. 90-15158
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of Referee Brown's order that: (1) awarded claimant temporary total disability from May 30, 1990 through August 12, 1990; and (2) awarded a penalty and attorney fee for temporary total disability due between July 23, 1990 and August 13, 1990. On review, the issues are temporary disability compensation and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, who worked as a long-haul trucker, experienced a compensable low back injury on August 21, 1989, when he was pulling a wheel from under a chip trailer. He complained of pain in the lumbar spine and pain and numbness in the right leg. Dr. Cullers, his then-treating chiropractor, referred claimant to Dr. Klump, neurosurgeon, for evaluation of a possible disc lesion. (Ex. 6). After a March 1990 MRI that revealed a disc bulge at L3-4, Dr. Klump recommended back exercise and an aerobic fitness program. (Ex. 11). Claimant continued to treat with Dr. Cullers for the same low back and right leg complaints. On April 16, 1990, Dr. Cullers released claimant to regular work. Claimant was not medically stationary.

Instead of returning to work, claimant took an unpaid medical leave of absence. During his leave of absence, claimant attempted to buy and operate a restaurant. He also continued to treat with Dr. Cullers through June 29, 1990, for the same complaints of low back and right leg pain, worse when sitting, and especially when driving.

On May 30, 1990, Dr. Bolton, M.D., examined claimant at the request of the insurer. Dr. Bolton noted pain in the right low back and down the right leg which is increased by sitting, especially by riding in a car or truck. Bolton diagnosed a chronic lumbar sprain and a probable lumbar disc herniation at L3-4. He took claimant off work pending a myelogram and CT scan to evaluate his low back. Shortly after this examination, Dr. Bolton retired.

On June 26, 1990, Dr. Cullers wrote to the insurer stating that claimant was not yet medically stationary. (Ex. 17). On July 7, 1990, Dr. Cullers wrote to the insurer concurring with Dr. Bolton's opinion that claimant should be off work.

On August 2, 1990, the insurer identified Dr. Cullers as claimant's current attending physician.

Claimant sought no further medical treatment until he saw Dr. Henderson, M.D., on August 13, 1990, upon the recommendation of the insurer. Dr. Henderson, like Dr. Bolton, recommended a CT scan, myelogram and discogram for evaluation before he could make treatment recommendations. The insurer instituted payment of temporary total disability compensation as of August 13, 1990.

On October 31, 1990, claimant underwent fusion surgery at L3-4.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Compensation

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. He awarded claimant temporary total disability compensation from May 30, 1990, through August 12, 1990, on the theory that Dr. Cullers remained an attending physician for 30 days or 12 visits after July 1, 1990 (see ORS 656.005(12)(b)(B)); or that Dr. Bolton was claimant's new attending physician because the insurer failed to ask Dr. Cullers for a concurrence prior to July 1, 1990.

The insurer first contends that, because claimant had removed himself from the workforce, Dr. Bolton's May 30, 1990, examination and report did not trigger the right to renewed time loss benefits. We disagree.

The determinative inquiry as noted by the Supreme Court in Cutright v. Weyerhaeuser, 299 Or 290 (1985), and as applied by the Court of Appeals in Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987), is whether claimant has lost wages because of an inability to work as a result of his compensable condition. Noffsinger, 88 Or App at 121.

Here, claimant elected to take a medical leave of absence from work because he did not think he could perform his work as a long-haul truck driver, which included driving, tarping chip truck trailers, and chaining up. Claimant's doctors had already taken him off work for several two-week periods after his injury. Each time claimant went back to work, he found that he was less able to perform his work, particularly throwing chains over the tires to chain up and crawling 40 to 60 feet to check the chip bins.

The medical evidence supports claimant's testimony. Both prior to and after claimant embarked on the leave of absence, he complained to his doctors of low back and right leg pain and that he had increasing difficulty with sitting, especially when driving. Then, six weeks into the leave of absence, Dr. Bolton recommended that claimant not work at least until tests could be performed that would indicate whether back surgery was appropriate. Based upon this evidence, we conclude that claimant has proven by a preponderance of the evidence that, as a result of his compensable injury, he was not capable of performing his regular work. Furthermore, during his leave of absence, claimant sought to operate a restaurant, which he thought would be within his diminished physical capabilities. Accordingly, we find that claimant had not left the work force.

Under the law in existence prior to July 1, 1990, claimant was entitled to temporary disability compensation until his claim was closed, or he was both medically stationary and released by the attending physician to return to regular work. Former ORS 656.268(1) and (2); Fazzolari v. United Beer Distributors, 91 Or App 592 (1988); Carmen Gusman, 42 Van Natta 425 (1990). Furthermore, under former OAR 436-60-030(5) and (6), the insurer was required to pay temporary partial disability compensation when an injured worker refused wage earning employment prior to claim closure until one of four events occurred: (1) claimant's attending physician returned claimant to temporary total disability status; (2) the offer of employment was withdrawn; (3) claimant's temporary partial disability benefits were terminated by a Determination Order or Notice of Closure in accordance with former ORS 656.268; or (4) temporary partial disability benefits had been paid for two years.

Although claimant is not requesting benefits for the period from April 16, 1990 to May 30, 1990, while he was on medical leave of absence, claimant became entitled to the resumption of temporary total disability payments if, prior to claim closure, the attending physician again authorized time loss. See former OAR 436-60-030(6)(a).

The insurer next contends that Dr. Bolton was not an attending physician and did not have the authority to authorize time loss benefits.

Under former OAR 436-60-005(2), an "attending physician" is a doctor who accepts the primary responsibility for the treatment of a worker's compensable injury. Here, it appears from the record that the insurer sent claimant to Dr. Bolton for an independent medical examination preparatory to claim closure. (See Tr. 9 and Ex. 16-6). Furthermore, claimant identified Dr. Cullers as his treating doctor and continued to treat with him through June 29, 1990. (See Tr. 9 and Ex. 18). Accordingly, we agree that Dr. Bolton was not an attending physician and did not have authority to authorize time loss benefits. See former OAR 436-60-005(2) and OAR 436-60-030(6)(a).

The insurer also contends that, because the law in effect as of July 1, 1990, does not grant chiropractors the right to authorize temporary disability and no medical doctor authorized such benefits until August 13, 1990, claimant is not entitled to any temporary disability benefits until that date. We are not persuaded by the insurer's argument.

Dr. Cullers was claimant's attending physician until July 1, 1990. Dr. Bolton reported that claimant was unable to work after May 30, 1990 due to the effects of his injury. The insurer, who had Dr. Bolton's report prior to July 1, 1990, requested verification of claimant's inability to work from Dr. Cullers, based on Dr. Bolton's report. Even though Dr. Cullers was no longer an attending physician after July 1, 1990, he was the appropriate attending physician to verify claimant's inability to work as of May 30, 1990. The insurer's apparently dilatory request to Cullers that arrived after July 1, 1990, should not be relied upon by the insurer to defeat claimant's right to receive temporary total disability compensation beginning May 30, 1990.

We are also not persuaded by the insurer's argument as it applies to temporary total disability benefits after July 1, 1990.

As a result of changes to the law pursuant to the 1990 amendments, the Department acknowledged that there may be workers eligible for or receiving time loss benefits based on the authorization of a physician who, on July 1, 1990, would become a non-attending physician. Therefore, to keep any such affected workers to a minimum, the Department issued the following requirement:

> "Insurers and Self-Insured Employers shall provide written notification to all workers with a deferred or accepted claim who are currently receiving medical services from a non-attending physician of the changes which go into effect on July first. The notice shall advise how the changes will affect the worker and what the worker will need to do to continue to receive time loss benefits or compensable medical services. Also, the notice must contain the insurer's contact person the worker may call to answer any questions about the changes. With the notice the insurer must include a list of 'attending physicians' in the worker's city. The worker shall be given 30 days written notice before any benefits may be terminated. A copy of the Notice to the worker must also be sent to the worker's medical service provider and to the worker's attorney, if represented." See Department of Insurance and Finance Bulletin No. 215 (June 8, 1990). (Emphasis supplied).

In the present case, although it appears that claimant received notice (see Tr. 12), there is no evidence as to when the notice was received by claimant. Without evidence covering the period of July 1, 1990 to to August 13, 1990, we decline to agree with the insurer that no benefits were due. See Sandra L. Masters, 44 Van Natta 1870 (1992) (employer was not entitled to unilaterally terminate claimant's temporary partial disability due to the fact that, as of July 1, 1990, the physician who had authorized time loss was no longer an "attending physician"). We accordingly conclude that the insurer had no authority to terminate or refuse to pay claimant's benefits at any time from July 1, 1990, until Dr. Henderson's August 13, 1990, examination. See Department of Insurance and Finance Bulletin No. 215 (June 8, 1990).

Consequently, based on the above reasoning, we affirm the Referee on this issue.

Penalties and Attorney Fees

The Referee found that the insurer unreasonably refused to pay compensation within 14 days of notice, or by July 23, 1990. Applying ORS 656.262(10), the Referee assessed a penalty equal to 25 percent of the amount of temporary disability benefits payable to claimant through August 12, 1990, with one half of the penalty to be paid to claimant and one half to his attorney. We reverse.

In deciding this issue, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. We too analyze this issue under the Workers' Compensation Act as amended, effective July 1, 1990. See Ida M. Walker, 43 Van Natta 1402 (1991).

Inasmuch as the insurer had a legitimate doubt as to the chiropractor's authority to authorize temporary disability after July 1, 1990, we reverse the Referee's opinion on this issue.

Inasmuch as the insurer 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 fee for claimant's attorney's services on review concerning the temporary total 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 of the interest involved.

ORDER

The Referee's order dated January 15, 1991 is affirmed in part and reversed in part. That portion of the order authorizing a penalty and associated attorney fee under ORS 656.262(10) is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,500 for services on Board review, to be paid by the insurer.

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February 24, 1993 Cite as 45 Van Natta 311 (1993)

In the Matter of the Compensation of
**DICK L. JORDAN, Claimant**
WCB Case No. 90-21935
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

Claimant requests review of Referee Garaventa's order that upheld the SAIF Corporation's partial denial of his claim for headaches, orthostatic dizziness, memory loss, cognitive problems, depression, Parkinsonian state, and tremor. On review, the issue is compensability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated July 19, 1991, is affirmed.

**Board Member Hooton dissenting.**

This case presents the question when, and whether, does it become unreasonable to continue to rely on certain medical evidence presented in a workers' compensation claim. In Garcia v. Boise Cascade Corp., 309 Or 292 (1990), the Supreme Court noted that "[a]n assertion of a finding of fact as a part of an explanation for disregarding evidence is subject to attack if that fact relied upon is not itself supported by substantial evidence." 309 Or 296. Continued reliance upon one or more medical reports in a workers' compensation claim is, or ought to be, subject to the same examination. Where further objective testing has ruled out an explanation relied on in a prior medical report, reliance on that report cannot be supported by substantial evidence in the record as a whole. That is the case here.

The majority affirms and adopts the Opinion and Order of Referee Garaventa whose reasoning is summed up in the following paragraph.

> "Claimant has had many physical symptoms and various diagnosed conditions off and on for most of his life. He sustained a compensable broken nose in 1976, but recovered and returned to regular work within three weeks. He suffered a myocardial infarction in 1985 and underwent heart bypass surgery in 1986. He is a chronic alcoholic.
>
> "I conclude that the evidence in this record does not preponderate in a finding that the 1976 injury was a material contributing cause of claimant's current condition..." Opinion and Order at 4.

Claimant suffers from symptoms consistent with organic brain dysfunction. The record examines three potential causes of claimant's condition. These include chronic alcohol abuse; multi-infarct dementia, a condition caused by anoxia, or the absence of oxygen to the brain; and, traumatic encephalopathy, a lesion which forms as a consequence of trauma to the brain.

Medical opinions have been received from five separate medical practitioners with varying areas of expertise. Dr. Kuttner, who stated that the compensable injury was the major cause of claimant's current condition provided no analysis, but deferred to the opinion of Dr. Knox. Because his opinion does not contribute to the analysis and resolution of the claim, it is given little weight.

Dr. Brooks presents a conclusion with, at best, an abbreviated analysis. He concludes that the 1976 injury couldn't be the cause of claimant's current condition for two reasons. First, he cites the delay in onset, noting that the condition has developed since a 1981 normal EEG. Second, he notes other possible causes including anoxia related to coronary infarctions, and a history of chronic alcohol abuse. (Exs. 32, 34 and 39).

Dr. Stolzberg also cites the absence of early documentation of brain injury and relies on other explanations for claimant's chronic brain disorder. Like Dr. Brooks, he cites multi-infarct dementia and alcohol abuse. He also notes the possibility of Alzheimer's Disease. (Ex. 33).

The analysis of Drs. Brooks and Stolzberg mirrors the analysis provided by the Referee. The conclusory opinion of Dr. Kuttner and the early conclusory opinion of Dr. Knox is not sufficient to rebut this medical evidence, if the record stopped here. Since there is no evidence that claimant suffers from Alzheimer's Disease, or that such a diagnosis is anything more than a possible explanation for organic brain dysfunction in some cases, this portion of the medical record would appear to establish either infarction-related anoxia or chronic alcohol abuse as a better explanation for claimant's organic brain dysfunction. Given claimant's extensive history with alcohol abuse, that would appear to be the most probable explanation, assuming, of course, that no additional medical evidence became available.

Drs. Brooks and Stolzberg raise anoxia as a possible cause of claimant's organic brain disorder, based solely on claimant's history of multiple infarctions. To meet this evidence, claimant produced a report from Dr. DeMot, claimant's treating cardiologist, and the only cardiologist to render an opinion in the present record. Dr. DeMot exhaustively and reliably explains that claimant's organic brain disorder could not have been caused by his myocardial infarctions. Claimant was in a medical facility at the time of each arrythmia requiring resuscitation. Resuscitation was prompt, without extended periods of anoxia and without evidence of any neurological effect at the time. He notes that the normal course for anoxia-induced mental dysfunction is that the patient begins in a severe state and improves over time. This is a history opposite of the actual course of claimant's disease. (Ex. 40).

As the only cardiologist on this record to address this question, and as claimant's treating cardiologist with the best information on claimant's cardiovascular history, the report of Dr. DeMot is entitled to great weight. Abbott v. SAIF, 45 Or App 657 (1980). The Board has ratified and adopted the rule expressed in Abbott, consequently, the Referee and Board must explain its reasoning in declining to apply it to the present claim. ORS 183.482(8)(b)(B).

Despite the fact that Dr. Knox initially provided only conclusory reports with little, if any, actual analysis, he responded to the reports of Drs. Brooks and Stolzberg with a report that sets out extensively the reasoning used to establish the diagnosis of traumatically induced organic brain dysfunction. He states that he originally examined claimant in 1981 and noted symptoms, even at that time, consistent with organic brain disorder, and included among the possible diagnoses an intracranial lesion. Therefore, he concludes that there is evidence, contrary to the assertions of Drs. Brooks and Stolzberg, that a degenerative brain process was already in the works in 1981. The first element of the causal analysis of both Dr. Brooks and Dr. Stolzberg is the long delay in onset from a 1976 injury, assuming that an EEG in 1981 ruled out the possibility that claimant was experiencing organic brain dysfunction to any degree at that time. The additional evidence provided by Dr. Knox, based on his own examination in 1981, substantially destroys that assumption.

He goes on to explain that claimant's condition is not consistent with chronic alcohol abuse. In deriving this conclusion, he relies, not upon claimant's history, as asserted by the Referee, but upon

objective scientific evidence derived from diagnostic testing. That well-reasoned analysis is entitled to great weight. Somers v. SAIF, 77 Or App 259 (1986). Drs. Brooks and Stolzberg do not discuss the diagnostic evidence, but rely solely on claimant's extensive alcohol abuse to support their conclusion on causation. To rely upon such speculation, when contrary diagnostic evidence is available and reported, is simply not reasonable.

In reaching her conclusion, the Referee relied upon speculation and possibility unsupported by an accurate history or objective medical testing. Reliance upon such speculation, when a correct history and objective medical testing demands a contrary result, strongly implies that the Referee's judgment has been clouded by the prejudicial impact of claimant's extensive alcohol history. While that history may provide some cause for discounting claimant's testimony, it is not a basis for ignoring objective medical evidence, or the concurrent histories taken by Dr. Knox in 1981, and by Dr. DeMot throughout claimant's cardiovascular treatment. Therefore, I must respectfully dissent.

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In the Matter of the Compensation of
**JOSEPH E. KELLY, Claimant**
WCB Case Nos. 91-06705 & 91-05122
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Kemper Insurance Company (Kemper), on behalf of Riddle Press, requests review of those portions of Referee Crumme's order that: (1) set aside its denial of claimant's claim for a left elbow condition and right wrist De Quervain's tenosynovitis; and (2) upheld the SAIF Corporation's denial, on behalf of Image Graphics and Litho, Inc., of the same conditions. On review, the issues 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 and his "Discussion of Findings," with the following supplementation.

## FINDINGS OF ULTIMATE FACT

Claimant's current left elbow and right wrist De Quervain's tenosynovitis conditions do not involve the same condition previously accepted by Kemper. However, claimant's current left elbow and right wrist conditions are work-related generally.

Claimant first sought treatment for his current left elbow and right wrist De Quervain's tenosynovitis conditions on February 12, 1991, during his employment with SAIF's insured.

Claimant's work activities during his employment with Kemper's insured were not the sole cause of these conditions. It was not impossible for claimant's work activities with SAIF's insured to cause them.

## CONCLUSIONS OF LAW AND OPINION

The Referee determined that SAIF is not responsible for claimant's current left elbow and right wrist conditions, because he found that the claim against SAIF is not compensable. In reaching this conclusion, the Referee applied the "major contributing cause" compensability standard as to SAIF. We disagree.

Compensability is a threshold issue in compensability/ responsibility cases. However, in this case, claimant relied on the last injurious exposure rule of proof as a substitute for proving actual causation. In such cases, the compensability question is whether the claimed conditions are work-related generally, not as to a particular insurer or employer. See Spurlock v. International Paper Co., 89 Or App 461, 464 (1988) ("As a rule of proof, [the last injurious exposure rule] relieves a claimant of the burden of proving specific causation as to any particular employment. The claimant need only prove that the disease was caused by an employment-related exposure."). Therefore, we find that, in this context, the "major contributing cause" compensability standard is inapplicable specifically as to SAIF.

Here, the medical evidence relating the claimed conditions to claimant's work activities generally, at both jobs, is undisputed. Therefore, we find that the claim is compensable and proceed to consider the responsibility issue.

The last injurious exposure rule also applies to the initial assignment of responsibility for an occupational disease among successive insurers, where there is no previously accepted claim for the same condition. See Fred A. Nutter, 44 Van Natta 854 (1992). Under the rule, where a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining 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 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).

In this case, claimant has not been disabled due to his left elbow and right wrist De Quervain's tenosynovitis conditions. He first sought treatment for these conditions on February 12, 1991, during his employment with SAIF's insured. Therefore, responsibility is initially assigned to SAIF. Inasmuch as SAIF has not established that claimant's work exposure with its insured could not have caused these condition or that his prior employment was the sole cause, responsibility remains with SAIF. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Claimant's counsel is entitled to an attorney fee for services on 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 attorney's services on review is $250, to be paid by SAIF, the responsible insurer. In reaching this conclusion, we have particularly considered the minimal time expended (as represented by claimant's respondent's brief).

## ORDER

The Referee's order dated August 19, 1991 is reversed in part, modified in part and affirmed in part. Those portions of the order that set aside Kemper Insurance Company's denial and upheld the SAIF Corporation's denial are reversed. Kemper's denial is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to it for processing according to law. SAIF shall pay the attorney fee awarded by the Referee, rather than Kemper. For services on review, claimant's counsel is awarded an attorney fee of $250, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
**TAMARA S. McCLUNE, Claimant**
WCB Case No. 91-10010
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

The insurer requests review of that portion of Referee Leahy's order that set aside its partial denial insofar as it denied claimant's claim for various left knee conditions. Claimant cross-requests review of that portion of the order that found that a suspected tear of claimant's left medial meniscus is not compensable. On review, the issue is compensability. We reverse in part and vacate in part.

FINDINGS OF FACT

Claimant compensably injured her left knee on April 8, 1991, when she stepped from the back of a truck to the ground and twisted her knee. She felt "popping" and "grinding" in the knee, followed by sharp pain. At the time of injury, claimant was working as an "auto shagger," unloading new cars from ships for processing. She told her foremen about the injury and completed her work shift. (Tr. 11-13).

After her shift, claimant sought medical treatment with Dr. Caron, who diagnosed left knee sprain and released her for work with a knee bandage. (Exs. 1, 3). Later that day, claimant filed a claim for sprained left knee; it was accepted by the insurer on April 15, 1991. (Ex. 2). Claimant did not miss any time from work.

Prior to the compensable injury, claimant sustained a left pelvic fracture in an off-the-job motor vehicle accident (MVA) in 1980. She was hospitalized and placed in traction for several weeks, with a traction pin in the distal portion of the left femur. (Ex. 28-2). The pin did not prevent claimant from moving her left knee. (Tr. 14). She was on crutches for some time after leaving the hospital. She missed over four months of work. (Ex. 28-2).

Following the 1991 compensable injury, claimant saw Dr. Bovard with complaints of popping and clicking in the knee. On May 13, 1991, Dr. Bovard noted popping, clicking and grinding in the knee. X-rays were interpreted as normal. He suspected internal derangement and a tear of cartilage or meniscus. (Exs. 4, 5).

An MRI scan on May 17, 1991 revealed: (1) degenerative changes involving the menisci, though a tear could not be confirmed; (2) possible mild chondrocalcinosis involving the medial compartment; and (3) mild chondromalacia of the patella, along with possibly a small loose body or unusual osteophyte in the patellofemoral joint. (Ex. 6)

On May 23, 1991, claimant saw Dr. Hayes, an orthopedic surgeon, on Dr. Bovard's referral. Dr. Hayes diagnosed possible torn cartilage and early medial compartment degenerative disease of the left knee. (Ex. 7). He considered arthroscopic surgery, but elected to follow-up on claimant's progress.

On June 12, 1991, the insurer closed the claim by Notice of Closure with no award of temporary or permanent disability. The notice indicated a medically stationary date of April 11, 1991. (Ex. 8). On June 21, 1991, the insurer issued a letter stating:

> "[W]e are accepting internal derangement and possible meniscus tear of the left knee injury sustained on 4-8-91 * * *. The remainder of your claim has been partially denied for degenerative changes of the menisci and chondrocalcinosis of the left knee. All medical bills for the temporary aggravation of injury to your left knee will be paid under ORS 656.245." (Ex. 9).

On July 18, 1991, claimant returned to Dr. Hayes with left knee soreness, which had been aggravated when she was digging and shoveling to help install a pool. (Ex. 13). Based on his examination and findings, Dr. Hayes recommended arthroscopic surgery, which was performed on July 29, 1991. The operation revealed that the principal problem was articular cartilage erosion. Dr. Hayes debrided the degenerative erosion in the medial compartment and released the lateral parapatellar area. He also trimmed a small tear of the posterior horn ligament. The post-operative diagnosis was moderate degenerative erosion of the medial compartment with chondromalacia patellar, tight lateral retinaculum, and lateral patellar shift. (Ex. 17). Claimant did not undergo physical therapy following the surgery.

Dr. Hayes released claimant for modified work as of September 9, 1991, with restrictions against climbing stairs or prolonged walking or standing. (Ex. 18). Claimant did not return to work, but, instead, sought treatment with Dr. Rusch, an orthopedic surgeon. Dr. Rusch diagnosed post-traumatic and post-operative knee pain and swelling with associated thigh atrophy. He recommended physical therapy and released claimant from work for three weeks. (Exs. 24, 25, 26).

On October 14, 1991, claimant was examined by Dr. Thompson at the insurer's request. Dr. Thompson, an orthopedic surgeon, diagnosed early degenerative arthritis of the left knee, along with muscle atrophy of the left thigh and calf. (Ex. 28).

## CONCLUSIONS OF LAW AND OPINION

Apparently relying on ORS 656.005(7)(a)(A), the Referee concluded that claimant had sustained her burden of proving that the compensable injury is the major contributing cause of her disability and need for treatment. We disagree.

Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990. Or Laws 1990 (Special Session), ch 2, § 54; Ida M. Walker, 43 Van Natta 1402 (1991).

The insurer accepted claimant's injury claim for a left knee sprain, internal derangement and possible meniscus tear. Notwithstanding that acceptance, the Referee concluded that the torn medial meniscus was not proved to be compensable. Claimant argues that because the meniscus tear was accepted, it is compensable. The compensability of that condition was not at issue at hearing, however. We, therefore, decline to address it in this case.

We turn to whether claimant's disability and need for treatment following the accepted injury were compensable. A preponderance of the medical evidence establishes that claimant had degenerative changes in the left knee which preexisted the 1991 injury. (Exs. 27, 28). Dr. Hayes opined that the knee had "primarily degenerative change with bilateral subluxation of the patella and early secondary changes," and that the knee was "aggravated by the injury." (Ex. 27). Dr. Thompson opined that the compensable injury caused the preexisting degenerative changes to become symptomatic. (Ex. 28-7). Based on this evidence, we find that claimant's disability and need for treatment are due to a combination of the compensable injury and a preexisting condition. However, the disability and treatment for the knee are compensable only to the extent that the compensable injury is the major contributing cause thereof. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Because this issue presents a complex medical question, its resolution turns largely on our analysis of the 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 medical evidence is divided. Dr. Bovard stated that he had "no information that would implicate any other mechanism of injury other than stepping off the back of a truck." (Ex. 19). It is not apparent from the record, however, that Dr. Bovard knew of claimant's degenerative knee condition. He last treated claimant on May 13, 1991, prior to the diagnostic tests and surgery which revealed the degenerative changes. We conclude that Bovard's opinion is not persuasive.

Dr. Hayes opined that the major contributing factors in the knee condition were the "degenerative change with bilateral subluxation of the patella and early secondary changes," but he added that the knee was aggravated by the compensable injury to the point that surgery was required. (Ex. 27). Although Dr. Hayes clearly believed that the injury caused the preexisting degenerative condition to become symptomatic and, therefore, contributed to the need for surgery, it is not clear whether he believed the injury was the major contributing cause of the current condition. Accordingly, we find Dr. Hayes' opinion insufficient to carry claimant's burden of proof.

Dr. Rusch opined that the compensable injury is the major contributing cause of the knee condition. (Ex. 29). However, he did not discuss the relative contribution of claimant's degenerative condition to the knee condition. It does not appear that he had a complete history of claimant's condition and treatment. His September 9, 1991 report refers to claimant's description of her knee surgery, but does not indicate that he had a copy of the surgical report. (See Ex. 26-1). His October 17, 1991 report, which attributed claimant's current knee condition to her work injury, does not include the diagnosis of the degenerative condition. (Ex. 29). For these reasons, we do not find Dr. Rusch's opinion to be persuasive.

Dr. Thompson opined that the major contributing cause of the knee condition and the need for surgery is the preexisting degenerative condition. (Exs. 28-7, 30). He explained that the degenerative condition developed slowly and could not have resulted from the injury, but that the injury caused the condition to become symptomatic. He maintained, however, that the preexisting condition is the primary cause of the need for surgery. He added that the lack of physical therapy following surgery resulted in atrophy and loss of strength, which are also contributing to claimant's disability and need for treatment. (Ex. 28-6).

Claimant argues that Dr. Thompson's opinion is unreliable because it is based on the assumption that, while she was in traction following the 1980 MVA, her knee was immobilized resulting in degenerative changes. We disagree. Although Dr. Thompson attributed claimant's degenerative condition to immobilization of the knee which he assumed to have followed the MVA (See Ex. 28-5), we do not agree that that assumption undercuts the persuasiveness of his opinion. Dr. Thompson merely offered an explanation for the degenerative condition. Though that explanation may not be correct, it is nevertheless undisputed that the degenerative condition developed slowly and preexisted the compensable injury.

After reviewing the medical evidence, we are most persuaded by the medical opinion of the treating surgeon, Dr Hayes, as supported by the opinion of Dr. Thompson. See Somers v. SAIF, 77 Or App 259, 262 (1986). We conclude that claimant has not sustained her burden of proving by a preponderance of the evidence that the compensable injury is the major contributing cause of her disability or need for treatment following the injury. Accordingly, claimant's disability and treatment following the injury is not compensable.

ORDER

The Referee's order dated November 21, 1991 is reversed in part and vacated in part. The insurer's denial of claimant's left knee degenerative condition is reinstated and upheld. The Referee's award of an assessed attorney fee is reversed. The Referee's order is vacated insofar as it found that a suspected tear of claimant's left medial meniscus is not compensable.

**Board Member Hooton dissenting.**

I am unable to support the majority resolution of this claim. While I acknowledge that ORS 656.005(7)(a)(A) and (B) apply to this claim, and claimant bears the burden of proving that her injury is the major contributing cause of her disability or need for treatment, I am forced, by common sense and the only reasonable interpretation of the medical record, to conclude that claimant more than met her burden.

As noted by the majority, four separate physicians have offered opinions regarding causation. However, unlike the majority, I cannot reach the conclusion that the medical evidence is divided. Each of these four physicians concluded that the cause of claimant's symptoms are her compensable injury. While claimant does have a preexisting degenerative condition, that condition resulted in no disability and no need for treatment. The degenerative condition was completely asymptomatic prior to the compensable injury. As a consequence of the injury, however, the previously asymptomatic condition was made symptomatic. The symptoms are the cause of the need for treatment. Surgical treatment rendered in the absence of any symptoms would ordinarily be considered unnecessary and unreasonable by the very same physicians who, on this record, argue that the preexisting condition is the major cause of the need for treatment.

Common sense tells us that individuals who have no limitations or symptoms as the result of a degenerative condition do not seek treatment. They are not even aware that the condition is present. To borrow a phrase oft repeated by a majority of the present Board with regard to administrative procedures, if it isn't broken don't fix it.

Because every physician on this record agrees that the injury caused claimant's condition to become symptomatic, I find the conclusion that the degenerative condition is the major cause of the disability or need for treatment to be incredulous. The analysis provided by the majority disregards the evidence which supports compensability, and decides the claim on the basis of the unsupported conclusions of those physicians who are willing to take the position that claimant's disability and need for treatment are unrelated to the cause of her symptoms. Therefore, I respectfully dissent.

In the Matter of the Compensation of
**ROBIN R. OLIVER, Claimant**
WCB Case No. 91-01800
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Peterson's order that: (1) declined to order the insurer to pay temporary disability compensation pursuant to a prior Referee's order pending appeal of that order; and (2) declined to assess a penalty and attorney fee for the insurer's refusal to pay the compensation. On review, the issues are claims processing nd penalties and attorney fees.

We affirm and adopt the Referee's order with the following supplemental comment and modification.

The court has recently issued a decision which is controlling in our resolution of this dispute. In Bird v. Bohemia, Inc., 118 Or App 201 (1993), the court affirmed a Board order which has held that a carrier was entitled to stay the payment of a widow's benefits under ORS 656.313 pending its appeal of a Referee's order which had found the deceased worker's claim compensable. In August 1990, a referee set aside a carrier's compensability denial and directed the carrier to provide benefits in accordance with law. When the carrier did not pay compensation to the decedent's widow, another hearing request was filed. Reasoning that the subsequent hearing request constituted a matter regarding a claim that was separate from the prior compensability matter, we concluded that the carrier was entitled to withhold payment of benefits under ORS 656.313. We relied on Oregon Laws 1990, (Special Session) chapter 2, section 54(2).

Arguing that the underlying compensability claim was the "matter regarding a claim," the claimant in Bird contended that former ORS 656.313 (which did not permit a stay of compensation pending appeal) was applicable under section 54(2). The court disagreed, reasoning that it was apparent that the term "matter" had a meaning that was different from the term "claim" and that it was intended to have a more narrow meaning than "claim." Inasmuch as the "matter regarding a claim" (the carrier's failure to pay compensation pending appeal) was not "in litigation" within the time constraints set forth in section 54(2) (a pre-May 1, 1990 hearing request and a pre-July 1, 1990 convened hearing), the court agreed with our conclusion that the carrier was entitled to stay the payment of compensation.

Here, as in Bird, the insurer's obligation to pay temporary disability compensation pursuant to a prior Referee's order was not a matter in litigation with a pre-May 1, 1990 hearing request and a pre-July 1, 1990 convened hearing. See also Raymond J. Seebach, 43 Van Natta 2687 (1991). Rather, the matter regarding a claim was in litigation when claimant requested a hearing on August 1, 1990 and a hearing was convened before Referee Podnar on December 26, 1990. It follows, therefore, that the litigation "savings" clause in section 54(2) of Oregon Laws 1990 (Special Session), chapter 2[1] did not apply to that proceeding. Accordingly, under amended ORS 656.313[2], the insurer was authorized to stay payment of temporary disability compensation which accrued before Referee Podnar's January 8, 1991 order, pending Board review of that order.

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[1] Section 54 (2) of the 1990 Act 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."

[2] Amended ORS 656.313(1)(a) provides:

"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; and

(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed."

The dissent argues that application of amended ORS 656.313 to stay the payment of temporary disability compensation pursuant to the prior Referee's May 23, 1990 order, which ordered the insurer to accept and process claimant's claim, is an absurd and unjust result. See Ida M. Walker, 43 Van Natta 1402 (1991). The dissent argues that former ORS 656.313 should be applied to preclude a stay of compensation because the prior Referee's order issued, and the insurer's obligation to pay compensation pursuant to that order arose, before the effective date of the 1990 amendments. We agree that under the law in effect before July 1, 1990, the insurer was obligated to pay compensation pending its appeal of the prior Referee's order. The question here, however, is whether we may apply pre-July 1, 1990 law in determining the insurer's obligation to pay compensation. We conclude that we cannot.

Oregon Laws 1990 (Special Session), chapter 2, section 54, governs the applicability of the 1990 amendments to the Workers' Compensation Law. Reviewing the language in section 54 as a whole, we have concluded that the legislature intended the 1990 amendments to apply retroactively to existing claims, with the exception of the "saved" by litigation or provided for in other sections of the 1990 Act. Ida M. Walker, supra.

Here, claimant's claim was in existence on and after July 1, 1990. As we found above, the claim was not "saved" by litigation. Further, the claim does not fall within any of the exceptions specifically enumerated in section 54 of the Act.

Nevertheless, we have also concluded that, notwithstanding the literal construction of section 54, the 1990 amendments will not be applied to a claim in existence on and after July 1, 1990 if such application would produce an absurd or unjust result and would clearly be inconsistent with the purposes and policies of the Workers' Compensation Law. Id. at 1406. In this case, however, we are not persuaded that retroactive application of amended ORS 656.313 would produce an absurd or unjust result or clearly be inconsistent with the purposes and policies of the Workers' Compensation Law.

We find this case to be analogous to Rocky L. Coble, 43 Van Natta 1907 (1991), aff'd Coble v. T.W. Krans & Sons, 116 Or App 62 (1992). There, the claimant suffered a compensable injury in 1989 and was receiving temporary disability compensation. On March 7, 1990, before the claimant had become medically stationary, and before the 1990 amendments became operative, the claimant's attending physician released him for regular work. The insurer unilaterally terminated temporary disability compensation as of that date. Claimant requested a hearing concerning the termination.[3] We applied amended ORS 656.268 to conclude that the insurer was authorized to terminate compensation, even though former ORS 656.268, which was in effect at the time of the work release, required the insurer to continue payment of compensation until claimant had become medically stationary. While recognizing that the insurer was required to conform its conduct to the law in effect at the time of its termination, we found nothing anomolous in a decision by the legislature to apply amended ORS 656.268 retroactively to all existing claims, thereby requiring the insurer's liability to be determined by the amended statute. The Court of Appeals affirmed our decision, concluding that amended ORS 656.268 is applicable to the claim. Id.

As in Coble, we recognize that the present insurer was required to pay compensation pursuant to the pre-July 1, 1990 law. Nevertheless, we find nothing anomolous in the legislature's decision to apply amended ORS 656.313 retroactively to all existing claims. See also Bryan L. Dunn, 43 Van Natta 1673 (1991) (held not absurd or unjust to allow insurer 90 days in which to accept or deny claim pursuant to amended ORS 656.262(6), even though the former statute in effect at the time of the claim and insurer's denial only allowed 60 days). Therefore, we determine the insurer's liability in accordance with the amended statute.

Finally, we note that the Referee dismissed claimant's request for hearing after ruling against her on the merits. However, since claimant did not withdraw the request for hearing and neither the employer nor insurer requested that the request for hearing be dismissed, we amend the order portion to state that the relief requested by claimant is denied.

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[3] Claimant requested the hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings' clause did not apply. See Or Laws 1990 (Special Session), ch 2, § 54(2).

ORDER

The Referee's order dated May 21, 1991 is modified. That portion of the order which purports to dismiss claimant's request for hearing is amended to state that the relief requested by claimant is denied. As amended, the Referee's order is affirmed.

**Board Member Hooton dissenting.**

The majority concludes that Raymond J. Seebach, 43 Van Natta 2687 (1991), controls the outcome of the present claim. I disagree.

In Seebach, an Opinion and Order establishing compensability of the claim issued on August 28, 1990. That order was appealed to the Board by the employer on August 30, 1990. The employer's first obligation to pay time loss under the order arose on September 11, 1990. At the time the Opinion and Order issued, the request for Board review was filed and the obligation to pay temporary disability compensation arose, ORS 656.313(1) stayed the payment of temporary disability compensation except that compensation that accrued from the date of the order. The question presented by the parties in Seebach was whether the litigation "savings" clause in section 54(2) prevented the insurer from taking advantage of ORS 656.313(1) as it existed on the date the obligation to pay past accrued temporary disability compensation actually arose. The same is true of the Courts decision in Bird v. Bohemia, Inc., 118 Or App 201 (1993). In that case the Opinion and Order giving rise to a request for review and the application of ORS 656.313(1) issued in August 1990 after the amendments to ORS 656.313(1) took effect.

In the present claim, the issue is very different. In this claim an Opinion and Order finding EBI responsible and requiring processing of the claim issued on May 23, 1990. The obligation to pay past due temporary disability compensation arose as a function of that processing obligation on June 6, 1990. EBI requested Board review of the May 23, 1990 Opinion and Order on June 21, 1990, two days before the order became final by operation of law. At the time of the Opinion and Order, the date that the obligation to pay temporary disability compensation first arose, and even on the date that the insurer requested Board review, former ORS 656.313(1) remained in effect. Former ORS 656.313(1) specifically 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 amendments to ORS 656.313(1) did not take effect until July 1, 1990, pursuant to section 54(1). Consequently, when the obligation to pay temporary disability compensation arose, and when EBI requested Board review, the law in effect prohibited a stay of compensation. Nevertheless, EBI did not pay.

The majority asserts that the present claim is analogous to Coble v. T.W. Krans & Sons, 116 Or App 62 (1992), in which the Court of Appeals affirmed a Board order which applied changes in the temporary disability statute to permit the insurer to unilaterally terminate the payment of temporary disability compensation prior to the effective date of the change in the statute. The majority is wrong.

In Coble, the claimant sought to prove his entitlement to temporary disability compensation and to obtain the compensation for the period from March 7, 1990 through the issuance of a Determination Order. Claimant had been released to return to regular work on March 7, 1990. By the terms of section 54 of SB 1197, amendments to ORS 656.268 were applicable to that claim and prevented an award of temporary disability compensation.

In the present claim, claimant need not demonstrate that he is entitled to temporary disability compensation. That entitlement was established by litigation conducted prior to the effective date of the amendments to the Workers' Compensation Law, when claimant established a compensable and disabling injury. What is at issue, in the present claim, is whether the stay provision of ORS 656.313(1) arises as a consequence of an act of the employer prior to the effective date of the amendments, that is, as a consequence of the employer's request for review, or whether that statutory provision is applicable as a result of claimant's request for hearing in an enforcement proceeding.

The answer is obvious. Entitlement is not at issue, only the right to a stay. The employer requested review under former ORS 656.313 and therefore has no right to a stay of compensation. To do otherwise violates the provisions of section 54 of SB 1197 which provide the effective date of the statute. Had the legislature intended the stay provision to be applicable in a dispute such as the case presently before us; it could, and would have included the stay provisions of ORS 656.313 in the exclusionary clause to the effective date found in section 54(1), along with the amendments to ORS 656.027, 656.211, 656.214(2) and 656.790. That exclusionary clause permitted the above referenced sections to take effect upon passage of the act on May 7, 1990.

The legislature did not include ORS 656.313 in that exclusionary clause. Instead, the amendments to ORS 656.313, together with the remaining amendments to the law became effective on July 1, 1990 pursuant to section 54 of the act. By its construction today, the majority ignores the legislative intent represented by the choice not to include the amendments to ORS 656.313 in the exclusionary clause and import those amendments into the exclusionary clause without any basis in law or fact.

This body is required to construe the Workers' Compensation Law liberally in favor of compensation. Reynaga v. Northwest Farm Bureau, 300 Or 255, 262 (1985). This is a well-established principle applicable to the Workers' Compensation Law by virtue of its character as a remedial statute. The principle has won the approval of the Supreme Court of the State. Nevertheless, the majority declines to apply, or even acknowledge, its existence. Instead, it construes the amendments liberally to deny compensation, and in so doing rewards the insurer for its disobedience of the law in effect at the time of its actions.

Based upon the language of its opinion, the majority demonstrates that it is applying Seebach because the enforcement proceeding came after July 1, 1990. The question in the enforcement proceeding, however, must still be whether the insurer had an obligation to pay benefits on June 6, 1990, or on June 21, 1990 which it did not fulfill.

I do no dispute that the legislature intended to change standards of compensability applicable to all claims existing on July 1, 1990. Consequently, some claims that were compensable on June 30, 1990, might no longer be compensable on July 1, 1990. However, these changed standards did not operate to remove legal obligations already in place. If an insurer had previously litigated the compensability of a claim combined with a preexisting condition, and lost that litigation under a material contributing cause standard, it was entitled to relitigate the issue under the current major cause standard as a current condition denial. It could not, however, simply ignore the obligations that arose as a result of its previous litigation. Unfortunately, that is precisely what the majority permits here.

By applying amended ORS 656.313(1) to a request for review filed before July 1, 1990, the majority presumes that the legislature intended to absolve the insurer of any penalty for failure to obey the requirements of the statute in force at the time an obligation arose. Such an interpretation of statute punishes those who voluntarily obeyed the law in effect between May 7, 1990 and July 1, 1990 and rewards those, such as the employer here, who obstinately refused to conform its conduct to the requirements of the law then in force because of its knowledge that on July 1, 1990 a more favorable law would go in to effect. Each of us, at all times, and in all circumstances, has the duty to obey the law in force at the time was act.

I have examined the legislative history with considered particularity and can find no intention to pardon insurers and employers for illegal conduct under the law in effect prior to July 1, 1990. In the absence of a clear expression of legislative intent, reflected in the language of the statute, I must call the majority resolution what is is, absurd and unjust. See Ida M. Walker, 43 Van Natta 1402 (1991). On that basis I would reverse the Referee and require the payment of all temporary disability compensation due and payable on June 6, 1990 with a 25 percent penalty on all amounts due and unpaid for the insurer's unreasonable resistance to the payment of compensation. See Carol D. Goss, 43 Van Natta 2637, 2639 (1991).

In the Matter of the Compensation of
**RONALD J. TROUT, Claimant**
WCB Case Nos. 90-22140 & 90-14935
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley and Hooton.

Claimant requests review of Referee Quillinan's order that: (1) upheld the self-insured employer's "back-up" denial of claimant's aggravation claim for a right great toe condition; and (2) upheld the employer's denial of claimant's occupational disease claim for a left great toe condition. On review, claimant contends that the backup denial was invalid or, alternatively, that he has established the compensability of his current condition as a new occupational disease. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's aggravation rights on the 1983 claim expired on May 16, 1990. On September 25, 1990, the employer denied the reopening of claimant's 1983 claim for his left toe condition under the Board's own motion. (Ex. 23).

On December 7, 1990, the employer issued a "back up" partial denial of claimant's right toe condition, which it had previously accepted on April 14, 1989 as an aggravation of the 1983 left ankle claim. (Ex. 27A).

On December 7, 1990, the employer denied the compensability of an October 4, 1990 new injury claim for claimant's left toe condition. (Ex. 27C).

On December 13, 1990, the employer denied the compensability of claimant's left toe condition as an aggravation of his 1983 left ankle claim. (Ex. 27D).

The parties agreed at hearing that the compensability of claimant's new occupational disease claims for the left and right toe conditions were before the Referee.

## CONCLUSIONS OF LAW AND OPINION

We affirm the Referee's order, with the following supplementation.

### Jurisdiction

Because claimant's aggravation rights from the 1983 injury had expired on May 15, 1990, the denial of temporary disability compensation for both the right and left toe conditions as related to that injury are under the Board's own motion jurisdiction (ORS 656.273(4)(a) and 656.278(1)(a)). In the present review, therefore, we treat the December 13, 1990 denial of the left toe condition as a denial of the compensability of medical services only, over which we retain jurisdiction pursuant to ORS 656.283. See ORS 656.245(2).

### Applicable Law

The Referee concluded that the issue of the back-up denial should be determined under the 1990 amendments. See Or Laws 1990 (Special Session), ch 2, § 54(2). Claimant contends that ORS 656.262(6) applies only prospectively, and not to claims accepted prior to the effective date of the 1990 amendments, based on the use of the present tense in ORS 656.262(6), which provides: "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable . . . [the carrier], at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial." (Emphasis added).

We have previously rejected claimant's interpretation in Eler M. Cousin, 44 Van Natta 2285 (1992). See Carlson v. Valley Mechanical, 115 Or App 371 (1992). We conclude that the Referee correctly applied the current version of ORS 656.262(6) to determine the validity of the back-up denial.

Backup Denial

Under ORS 656.262(6), it is the employer's burden to prove by clear and convincing evidence that the claim is not compensable. We agree with the Referee that the employer carried its burden, and we adopt those portions of her opinion entitled "Backup denial of right great toe" and "Compensability right toe."

Occupational disease

We affirm and adopt this portion of the Referee's opinion.

ORDER

The Referee's order dated September 12, 1991 is affirmed.

**Board Member Hooton dissenting.**

The resolution of this claim involves a dispute that is primarily factual in nature. Ordinarily, a dissent on such a claim has little value, except as entertainment. The problem in this case involves a method of fact finding which leads to an anomolous result. I can't, in good conscience, lend credibility to a fact finding process that is inimical to the preponderance of the evidence standard of proof, solely because the Court of Appeals, under its substantial evidence standard, may be powerless to correct the error.

This case involves a complex medical question regarding the causation of claimant's hallux rigidus. This condition is an advanced state of arthritic growth which prevents normal motion in the great toe. It affects both feet in this claimant.

There are two medical opinions on causation in this record. As noted by the Referee, in an opinion adopted by the majority, Dr. Bert, claimant's treating physician, has concluded that work is the major cause of the claimant's disability or need for treatment. Dr. Hardiman, on the other hand, considers the major cause of claimant's current condition to be a preexisting deformity of the metatarsal head. The curious problem, which makes this case vastly different from most factual disputes, is that, while Dr. Bert's opinion is conclusory and supported by only a minimal analysis, Dr. Hardiman provides an in-depth understanding of the causes and contributing factors, but states a conclusion that is contrary to the reasoning provided. If the conclusion of Dr. Bert is combined with the reasoning provided by Dr. Hardiman, claimant has established a compensable claim. However, the Referee declines to do so. Instead, the Referee entirely disregards the opinion of Dr. Bert because of its conclusory nature, and then relies upon the conclusion of Dr. Hardiman, because of his reasoning, even though his conclusion is inconsistent with the reasoning provided. Under these circumstances it is, not only appropriate, but mandatory, that the Referee and the Board consider the entire record without regard to authorship, and determine the compensability of claimant's condition based on the combination of the medical evidence.

In Garcia v. Boise Cascade Corp., 309 Or 292 (1990), the Supreme Court noted that under the substantial evidence standard of review, "where evidence is rejected or disregarded by the referee, and such action purports to be based on facts, it is appropriate for the reviewing court to examine whether the referee's decision is supported by substantial evidence. Put another way: An assertion of a finding of fact as part of an explanation for disregarding evidence is subject to attack if that fact relied upon is not, itself, supported by substantial evidence." 309 Or at 296. This is such a case.

Dr. Hardiman explains that hallux rigidus begins as a flattening deformity of the metatarsal head. (Ex. 29-16.) This condition is not customarily caused by an individual's employment. It can result from congenital factors contributing to the formation or development of the metatarsal head, or, in rare cases, can occur as the result of significant trauma or extreme loading. Dr. Hardiman is quite clear

that ordinary employment exposure is not sufficient to cause this deformity. The trauma necessary to result in this condition might occur with extended soccer playing or as the result of ballet dancing, both of which involve direct trauma to, or loading of, the toe. Given that significant trauma is necessary as a causal factor, it is clear that the probable cause of the metatarsal head deformity in this individual is most likely to be congenital in origin.

However, flattening of the metatarsal head is not the condition in dispute here, and the causation of that condition is not the same question as the causation of the condition in dispute. Dr. Hardiman's causal conclusions, however, derive from this condition, rather than the condition at issue.

Hallux rigidus results from the combination of a preexisting flattened metatarsal head with the effects of time and activity. Dr. Hardiman explained this relationship to be analogous to a misaligned automobile tire. With time and mileage, misalignment leads to greater than normal deterioration of the tread. In hallux rigidus, time and use, or loading, causes a greater than normal degeneration of the joint. (Ex. 29-33.)

Assuming that claimant's life span could be extended indefinitely, even the relatively minimal activity level of a "couch potato" could cause the development of hallux rigidus, if Dr. Hardiman's analysis regarding the function of time and use is correct. The longer claimant uses the deformed joint, or the more vigorous the activity, the greater the degree of degeneration that results, until claimant ultimately experiences symptoms that require treatment and result in disability due to the total breakdown of the joint structure and the resultant formation of arthritic growths. However, claimant has not experienced minimal use, or even an activity level consistent with the average daily activities of most individuals. The record establishes that claimant worked for 35 years in an employment that caused him to be continuously on his feet, walking and otherwise loading the toe joints. Certainly, if the degeneration is a function of time and use, claimant developed his need for treatment and disability faster than he otherwise would solely as a result of the activity required by his employment. Indeed, if Dr. Hardiman is correct, and one considers both the kind and duration of the occupational exposure, the only possible inference is that claimant could not have lived long enough to experience disability or a need for treatment absent the occupational exposure.

Though this analysis is more than sufficient to establish the compensability of this claim, Dr. Hardiman goes even further. He indicates that there is a correlation between the degree of degeneration and the symptoms that result in disability. (Ex. 29-34.) This means that a worsening of symptoms correlates to a worsening of the underlying disease process and is an indication of pathological change. It also gives the lie to Dr. Hardiman's conclusion that claimant's work is the cause of a symptomatic worsening, but not of the pathological process.

On this record, claimant has established the compensability of his bilateral hallux rigidus because the reasoning of Dr. Hardiman is consistent with Dr. Bert's conclusory causal statement and is inconsistent with Dr. Hardiman's own conclusions. The total record supports the claim. The reasoning of the Referee, adopted by the majority, indicates that neither the Referee nor the majority examined the record as a whole. It is apparent that the Referee weighted the opinion of each medical specialist independently, based upon its "persuasiveness" and then accepted one opinion in its entirety, rejecting all others.

The question of "persuasiveness" creates its own problems in the evaluation of evidence and the standard of proof. "Persuasiveness" is a nebulous standard that differs for every finder of fact. It is ultimately subjective and, therefore, a reflection of an internal bias. The question of persuasiveness does not relate to the greater weight of the evidence, but to the background, education, and personal biases of the finder of fact. Where persuasiveness is used as the evidentiary standard, law is reduced to whim, and advocacy to sophistry.

Even if the evidence is tortured, or ignored, to support a conclusion that claimant has failed to meet the burden of proof on the compensability of bilateral hallux rigidus, the internal contradiction in Dr. Hardiman's testimony destroys any hope that the employer could meet its "clear and convincing" burden to support the back-up denial of claimant's hallux rigidus of the right great toe.

nerve damage, atrophy or other anatomical changes, we do not find that claimant has established an entitlement to any ratings for his right forearm. See former OAR 436-35-110(2); Lawrence E. Wilson, 43 Van Natta 1131 (1991).

Claimant contends that former OAR 436-35-110(2)(b) and (c) are inconsistent with ORS 656.214(3). Specifically, claimant asserts that former OAR 436-35-110(2)(b) and (c) have expanded the precise language of ORS 656.214(3). Thus, claimant argues that the rules limit the ability of a referee to allow for an actual loss of strength in the hand and arm when there has been a loss of effective opposition. We disagree.

Administrative rules must be consistent with an agency's statutory authority. The agency may not alter, amend, enlarge or limit the terms of an application statute by rule. Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988). The pertinent rules here are not inconsistent with the agency's statutory authority. ORS 656.214(3) does not require the Director to allow for a loss of strength in the hand and arm when there has been a loss of effective opposition. Rather, the statute provides that a proportionate loss of use may be allowed for an uninjured finger or thumb where there has been a loss of effective opposition. Moreover, ORS 656.726(3)(f) gives authority to the Director to define standards for evaluating disabilities. The particular rules challenged here were adopted under that authority and are not inconsistent with ORS 656.214. See Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992).

Finally, in calculating claimant's permanent disability for the index finger, the impairment values of the interphalangeal and metacarpalphalangeal joints due to impaired motion are first combined (not added). Former OAR 435-35-060(5). Then the impairment values due to abnormal motion, decreased sensation and amputation are combined (not added) to obtain the total impairment. Former OAR 436-35-060(7).

Here, the 30 percent loss of flexion to the interphalangeal joint is combined with the 18 percent loss of flexion to the metacarpalphalangeal joint for an impairment value of 36 percent. When the 36 percent impaired motion value is combined with the 65 percent loss due to the index finger amputation and the 18 percent loss of sensation, the combined values equal a total impairment value of 82 percent of the index finger. The 20 percent thumb loss of opposition due to the amputation is not contested. See former OAR 436-35-040(3). Accordingly, we reverse the Referee's scheduled permanent disability award and reinstate the Order on Reconsideration award of 20 percent for loss of opposition of the right thumb and 82 percent for loss of the right index finger.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.2154(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992), rev den 315 Or 271 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2). Therefore, we reverse that portion of the Referee's order which directed the insurer to pay claimant's scheduled permanent disability award at the rate of $305 per degree.

Vocational Assistance

In the Review and Order, the Director found that claimant had been released to return to his regular work without restrictions on July 8, 1991. Accordingly, claimant was disqualified from vocational assistance on that basis. See OAR 436-120-040. Finding that the evidentiary record supported the Director's findings, the Referee concluded that the Director did not abuse his discretion in determining that claimant was ineligible for vocational assistance. See ORS 656.283(2); Warren G. Bascom, 44 Van Natta 2416 (1992). Accordingly, the Referee did not disturb the Director's Review and Order. We affirm.

In the Matter of the Compensation of
**JOHN R. COYLE, Claimant**
WCB Case No. 91-14674
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of those portions of Referee Myers' order which: (1) awarded 33 percent (50 degrees) scheduled permanent disability for the right forearm in lieu of 20 percent (9.6 degrees) scheduled permanent disability for loss of the right thumb and 82 percent (19.68) scheduled permanent disability for loss of the right index finger, as awarded by the Order on Reconsideration; and (2) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the Referee's order that affirmed a Director's Review and Order finding that claimant was not eligible for vocational assistance. On review, the issues are extent of scheduled permanent disability, rate of scheduled permanent disability, and vocational assistance. We reverse in part and affirm in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Extent of Scheduled Permanent Disability

Claimant was medically stationary on April 26, 1991 and the claim was closed by Notice of Closure dated May 8, 1991. Therefore, former OAR 436-35-010 through 436-35-260 apply. (WCD Admin. Order 2-1991).

In lieu of 20 percent for loss of the right thumb and 82 percent for loss of the right index finger, as awarded by the Order on Reconsideration, the Referee awarded 33 percent scheduled permanent disability for the right forearm. In arriving at this conclusion, the Referee calculated an 84 percent total loss of the index finger and converted this loss into a 14 percent loss of the hand. The Referee factored out the 20 percent loss of opposition of the thumb. Finally, the Referee combined the 14 percent hand value with a 22 percent loss of strength value for a total award of 33 percent disability to the forearm. We disagree with the Referee's ultimate finding for several reasons.

Claimant injured only one finger. The Order on Reconsideration awarded an 82 percent loss of the right index finger and a 20 percent loss of the right thumb based on opposition due to the amputation of the finger. The applicable standards do not provide for conversion of thumb/finger impairment values into a hand value unless there is a loss of use of two or more digits without considering opposition. Former OAR 436-35-040(6). Therefore, we find that the index finger and opposition loss to the right thumb are not converted to loss of the hand.

The Referee equated claimant's loss of grip strength due to decreased ranges of motion in the hand to a 50 percent loss. The Referee multiplied this loss by a 44 percent loss due to median nerve damage for a total of 22 percent loss of the forearm. We disagree.

First, we do not find that claimant is entitled to impairment for median nerve damage. There is no medical evidence indicating that claimant sustained nerve damage or that any alleged nerve damage resulted in a loss of strength pursuant to former OAR 436-35-110(2).

Next, former OAR 436-35-110(2) provides that decreased strength due to an amputation receives no rating in addition to that given for the amputation and decreased strength due to a loss of range of motion

Here, claimant suffered an amputation at the mid-portion of the middle phalanx of his index finger. The medical arbiter, Dr. Fitzsimmons, related claimant's loss of grip strength to his "inability to fully utilize the index finger and the protective aspect that the patient has with this finger." (Ex. 6-4). Inasmuch as Dr. Fitzsimmons has not specifically attributed claimant's loss of grip strength either to

Under ORS 656.283(2), a worker who is dissatisfied with his vocational assistance must first apply to the Director for administrative review before requesting a hearing. The statute further provides that the decision of the Director may be modified if it:

"(a) Violates a statute or rule;
"(b) Exceeds the statutory authority of the agency;
"(c) Was made upon unlawful procedure; or
"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

Claimant contends that abuse of discretion occurred because the Director's order did not take into account the November 1991 medical arbiter's report which provided that claimant could not return to his regular work as a sawyer but that he functioned very well in his capacity as a part owner of a baseball card shop. Further, claimant contends that in order to conduct a review of the Director's order, it is necessary to conduct a hearing in order to create a record for the referee or the Board to determine if the Director abused his discretion.

The Court of Appeals has recently addressed this issue. In Colclasure v. Wash. County School Dist. No. 48-J, 117 Or App 128 (1992), the court found that in determining claimant's eligibility for vocational assistance, the Director is not required to conduct a hearing or to make findings. Thereafter, on the basis of the historical record developed before a referee, the referee may make findings of ultimate fact to determine whether the Director's order is subject to modification for any of the specific reasons in ORS 656.283(2). Id.; Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992). On review, to determine whether the Director's order is subject to modification, the Board reviews the record made by the referee but may make findings of ultimate fact different from those made by the referee. Id.

Warren G. Bascom, supra, is helpful in illustrating the differences in our review authority under ORS 656.283(1) and (2). In Bascom, we found that for purposes of determining the claimant's rate of temporary disability, he should be considered as a regular "overtime" worker under OAR 436-60-025(5)(e). In addition, upon review of the Director's vocational assistance order under ORS 656.283(2), we concluded that the Director had substantial evidence from which to find that claimant was only a temporary employee when he was injured. Therefore, despite our decision on the "temporary disability rate" issue, we concluded that the Director did not abuse his discretion in finding that claimant was a temporary employee.

Here, based on the record before us, we find that the Director had substantial evidence from which to conclude that claimant had been released to return to regular work without restrictions. See Exhibit 4. Therefore, notwithstanding the subsequent medical arbiter's report, we agree with the Referee that the Director did not abuse his discretion in finding that claimant was ineligible for vocational assistance. We, therefore, adopt that portion of his order. Accordingly, the Director did not violate a rule when he applied OAR 436-120-025(1)(b).

Alternatively, claimant requests that the case be remanded to the Director, alleging that the record before the Director was incomplete because it did not include the November 21, 1991 medical arbiter's report. Our statutory authority in vocational assistance is limited to modification of the Director's order. ORS 656.283(2). Therefore, we deny the motion. Furthermore, there are other available procedures for the redetermination of vocational assistance eligibility. See OAR 436-120-055(1), (2).

## ORDER

The Referee's order dated March 20, 1992 is reversed in part and affirmed in part. The Referee's award of 33 percent (50 degrees) scheduled permanent disability for the right forearm and award of an attorney fee out of that increased compensation are reversed. The Order on Reconsideration scheduled permanent disability awards of 20 percent (9.6 degrees) for loss of the right thumb and 82 percent (19.68) for loss of the right index finger are reinstated and affirmed. That portion of the Referee's order which directed the insurer to pay claimant's scheduled permanent disability award at the rate of $305 per degree is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**ROY DRAKE, Claimant**
WCB Case No. 90-15981
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Schultz's that: (1) set aside its de facto denial of claimant's disc bulge claim; (2) set aside its denial of proposed surgery; and (3) set aside an Order on Reconsideration on the ground that claimant's claim was prematurely closed. In addition, the insurer seeks review of the Referee's admission of additional evidence and the consideration of supplemental requests for hearing following the granting of a continuance. On review, the issues are evidence, supplemental requests for hearing, compensability of medical services, and premature closure. We affirm in part and vacate in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

The initial hearing was continued by the Referee for the deposition of Dr. Misko, claimant's treating surgeon. In addition, the Referee "froze" the record, except for the deposition transcript and any rebuttal evidence submitted by claimant. (Tr. 4).

When the hearing reconvened approximately 13 months later, the insurer objected to the inclusion of additional medical records submitted after the initial hearing date, other than Dr. Misko's deposition transcript. The Referee overruled the objection on the basis that, due to the passage of time, additional evidence was required for the completion of the record. (Tr. 6).

ORS 656.283(7) provides that "the referee is not bound by common law or statutory rules of evidence * * * and may conduct the hearing in any manner that will achieve substantial justice." This statute is interpreted as giving broad discretion to the Referee with regard to evidentiary rulings. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Therefore, we review the Referee's rulings for abuse of discretion.

The insurer asserts that it relied to its detriment on the Referee's initial statement that the record was "frozen." However, it appears that the insurer was aware of the Referee's evidentiary ruling more than a month before the continued hearing (Tr. 7-8), but did not request a continuance to rebut the additional evidence. See OAR 438-06-091(2); Ronnie D. Ratliff, 44 Van Natta 850, 851 (1992). From the aforementioned circumstances, we conclude that the Referee did not abuse his discretion. Therefore, we will not disturb his evidentiary ruling.

### Supplemental Requests for Hearing

The insurer also asserts that it was prejudiced in that the Referee initially "froze" the record, but later considered claimant's supplemental requests for hearing. The supplemental requests contested the insurer's alleged de facto denial of an L4-5 disc defect, asserted that the insurer failed to pay temporary total disability, had not complied with ORS 656.308(2) and was, therefore, time-barred from contending that claimant's need for surgery resulted from an earlier injury with another employer.

OAR 438-06-031 allows for the raising of issues throughout the course of a hearing, provided that the evidence supports the issue not previously raised. The Referee may also continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue. Id.

We conclude that pursuant to OAR 438-06-031, it was within the Referee's discretion to consider claimant's supplemental requests for hearing and that, if the insurer was prejudiced by this ruling, its remedy was to seek an additional continuance. The insurer, however, did not move for a continuance. We, therefore, do not disturb the Referee's ruling.

Neither do we disturb the Referee's decision to set aside the insurer's de facto denial of claimant's bulging disc at L4-5; the insurer's sole reason for contesting the decision is that the Referee should not have considered claimant's supplemental requests for hearing. We have previously decided that the Referee's rulings in that regard were proper.

Compensability of Medical Services

The Referee concluded that claimant's surgery request was the reasonable and necessary result of his compensable injury.

The Board and Hearings Division have subject matter jurisdiction to determine the causal relationship between a compensable injury and the need for medical services. Michael A. Jaquay, 44 Van Natta 173 (1992). However, when the dispute concerns whether or not a medical service is reasonable and necessary, i.e., "excessive, inappropriate, ineffectual or in violation of rules" under ORS 656.327(1)(a), original jurisdiction rests solely with the Director. See Stanley Meyers, 43 Van Natta 2643, 2645 (1991).

We conclude that jurisdiction over the present medical services dispute lies with the Director. The Referee, therefore, lacked jurisdiction to review the dispute, and we vacate that portion of his order that addresses the compensability of claimant's requested surgery. On review, our jurisdiction is limited to a review of the causal relationship between the compensable injury and proposed surgery.

In 1978, claimant sustained a compensable injury while working for an employer not subject to this claim. That injury resulted in two laminectomies, both at L4-5. Claimant then sustained a second compensable injury in September 1988 while working for another employer, covered by Liberty Northwest Insurance Corporation. That injury resulted in back surgery at L5-S1. Claimant's treating neurosurgeon, Dr. Misko, then requested authorization for additional lumbar surgery at L4-5.

At hearing, the insurer sought to avoid responsibility for claimant's surgery request by asserting that the 1978 injury caused the need for medical services. Finding that the insurer had failed to issue a disclaimer of responsibility under ORS 656.308(2), the Referee concluded that the insurer was barred from asserting that responsibility rested with another carrier. We agree.

ORS 656.308(2) requires a carrier to provide written notification of its intent to disclaim responsibility for a claim on the basis that the worker's injury resulted from an exposure with another employer. Here, we agree with the Referee that the insurer's failure to follow the notification process required by ORS 656.308(2) now precludes it from arguing that an earlier employment exposure caused claimant's need for medical services. See Byron E. Bayer, 44 Van Natta 1686-1687 (1992); Richard F. Howarth, 44 Van Natta 1531-1532 (1992).

Claimant, however, continues to have the burden of proving that his need for surgery is compensably related to his 1988 injury. Therefore, we proceed to the merits of claimant's medical services claim.

ORS 656.245(1) provides that for every compensable injury, medical services for conditions resulting from a work-related injury are also compensable. In this case, every physician providing a medical opinion regarding causation stated that claimant's previous surgery at L5-S1 was at least a material contributing cause of his need for additional surgery at L4-5. (Exs. 40A, 41-27, 42-7). Thus, because the surgery at L5-S1 was performed to treat claimant's 1988 compensable injury, we conclude that the requested surgery at L4-5 is likewise compensably related to the 1988 injury.

Premature Closure

We adopt that portion of the Referee's order regarding this issue.

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for prevailing against the insurer's request for review. 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 services on review is $1,500, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated February 14, 1992 is affirmed in part and vacated in part. That portion of the order addressing the reasonableness and necessity of the proposed surgery is vacated. The remainder of the order is affirmed. For services on review, claimant's attorney is entitled to an assessed fee of $1,500, to be paid by the insurer.

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In the Matter of the Compensation of
**STEVEN R. HOLMES, Claimant**
WCB Case Nos. 91-17846 & 91-16939
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Thomas Gooding (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Davis' order that awarded claimant a $1,200 attorney fee for prevailing against SAIF's compensability denial. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Finding that, in effect, claimant had prevailed in the matter of compensability, the Referee awarded claimant an assessed attorney fee of $1,200, apparently pursuant to ORS 656.386(1). We agree that claimant is entitled to an attorney fee; however, we conclude that claimant is entitled to the fee pursuant to ORS 656.382(1). We base our conclusion on the following analysis and reduce the attorney fee award.

SAIF denied both compensability and responsibility for claimant's right carpal tunnel syndrome (CTS). At hearing and on review, claimant argued that SAIF's denial of compensability was unreasonable. We agree.

The record establishes that SAIF had no legitimate basis to doubt compensability as to some employer at the time of its denial of compensability. The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985). Here, all of the reports, both before and after SAIF's denial, relate claimant's CTS to his work activities as an electrician's apprentice. Thus, SAIF's denial of compensability was unreasonable.

SAIF's unreasonable denial of compensability precluded the possibility of the designation of a paying agent pursuant to ORS 656.307 and constituted an unreasonable delay in the payment of compensation. As discussed below, claimant would be entitled to a penalty pursuant to ORS 656.262(10) for SAIF's unreasonable denial of compensability but for the fact that there were no "amounts then due" at hearing because Liberty Northwest accepted the claim prior to hearing. Instead, as discussed below, claimant is entitled to an assessed attorney fee pursuant to ORS 656.382(1).

In Harold R. Borron, 44 Van Natta 1579 (1992), although we upheld the insurer's denial of responsibility for a knee condition, we found that the insurer had unreasonably denied compensability of that condition because there was no evidence that the condition was not work-related. Relying on Kim S. Jeffries, 44 Van Natta 419 (1992), we assessed a penalty against the nonresponsible carrier for this unreasonable compensability denial. We based the penalty on all compensation due from the responsible carrier at the time of the hearing, including medical services. Ben Santos, 44 Van Natta 2228, on recon 44 Van Natta 2385 (1992).

Furthermore, in a similar case, the Court of Appeals upheld assessment of a penalty against a nonresponsible carrier for its unreasonable denial of compensability. SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983). In Moyer, the court found that the nonresponsible carrier's denial of compensability was unreasonable because the only evidence regarding causation stated that the claimant had sustained a new work related injury. The court also found that this denial resulted in delay of payment of compensation by preventing the designation of a paying agent pursuant to ORS 656.307.

In addition, the court rejected the carrier's argument that, even if a penalty could be assessed under former ORS 656.262(9) [now ORS 656.262(10)], there were no "amounts then due" from it as the nonresponsible carrier. SAIF v. Moyer, supra at 503. The court reasoned that the carrier would have it add to the statute the words "from the insurer against whom the penalty is assessed" after the words "amounts then due." The court found that "[n]o authority exists for that construction, and it would defeat the purpose of penalties to encourage insurers to withhold benefits." Id.

We find that the same reasoning applies to the current version of the statute. Thus, we find that a penalty may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent. This penalty may be based on the "amounts then due" from the responsible carrier.

However, here, Liberty Northwest accepted compensability of the claim before hearing and there is no evidence of any "amounts then due" at the time of hearing upon which to base a penalty pursuant to ORS 656.262(10). Nevertheless, where a carrier has unreasonably resisted the payment of compensation, we may assess an attorney fee in the absence of amounts of compensation "then due." See ORS 656.382(1); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Accordingly, we find that claimant 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 attorney fee for claimant's counsel's services concerning the unreasonable denial issue is $750, 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, and the value of the interest involved. Consequently, we reduce the Referee's $1,200 attorney fee award to $750.

Claimant is not entitled to an attorney fee on review for defending against the attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

## ORDER

The Referee's order dated June 17, 1992 is modified in part and affirmed in part. In lieu of the Referee's assessed attorney fee award of $1,200, claimant is awarded an assessed attorney fee of $750, to be paid directly to claimant's attorney by the SAIF Corporation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**JERRY O. HOUSER, Claimant**
WCB Case No. 90-08838
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Hazelett's order which declined to award claimant assessed attorney fees under ORS 656.386(1) for his counsel's alleged efforts in obtaining rescission of the self-insured employer's denial of a "new injury" claim without a hearing. 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

Claimant seeks an assessed attorney fee under ORS 656.386(1) for his attorney's services in obtaining rescission of the employer's "new injury" denial without a hearing. The Referee held that by accepting an aggravation claim, there remained no question of compensability and therefore, claimant's counsel is not entitled to an assessed attorney fee under ORS 656.386(1). We disagree.

The employer simultaneously accepted an aggravation claim and denied compensability of a new injury which claimant alleges he sustained on January 4, 1990. (Ex. 7-1). We find nothing in the employer's denial that concedes compensability of the new injury. Accordingly, we find that claimant is entitled to an assessed attorney fee under ORS 656.386(1) if his counsel was instrumental in obtaining compensation without a hearing. See Fidel D. Chavez, 43 Van Natta 2515 (1991).

The employer contends that our decision in Jerry F. Foster, 38 Van Natta 1373 (1986), on recon 39 Van Natta 65 (1987), aff'd Western Employer's Insurance v. Foster, 90 Or App 295 (1988), holds that merely obtaining new aggravation rights does not entitle claimant to an assessed attorney fee. We disagree. Foster is not controlling here because the present case does not involve a responsibility dispute.

Moreover, we have previously held that by obtaining rescission of a "new injury" denial, a claimant's attorney obtains compensation for the claimant, even though an aggravation claim had been previously accepted. Fidel D. Chavez, supra. Here, it is apparent from the file that claimant has made claims for compensation for medical services and temporary disability in relation to his January 1990 injury. Given his success in overturning the denial, these benefits will become payable under the January 1990 claim. Accordingly, we conclude that claimant's counsel "obtained compensation" for claimant.

Finally, we find that claimant's counsel was instrumental in obtaining compensation for claimant. Claimant's counsel filed a request for hearing on April 24, 1990, challenging the employer's denial of April 11, 1990. By doing so, counsel preserved claimant's right to challenge the denial. In addition, claimant's counsel represents that, after filing the request for hearing, he reviewed discovery materials and 138 exhibits produced by the employer's counsel on May 18, 1990. Claimant's counsel further represents that he engaged in discussions with the employer's counsel before the denial was rescinded on July 30, 1990. Although the employer contends that claimant's counsel's efforts did not cause it to rescind the denial, it does not deny that discussions took place between counsel prior to the employer's rescission. Under these circumstances, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1).

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee concerning the pre-hearing rescission of the employer's denial is $1,500, 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 the record), the value of the interest involved, and the risk that claimant's attorney's efforts will go uncompensated.

ORDER

The Referee's order dated May 7, 1992 is reversed. For claimant's counsel's pre-hearing services which were instrumental in obtaining compensation for his client, claimant's attorney is awarded a reasonable assessed attorney fee of $1,500, to be paid by the self-insured employer.

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February 25, 1993 Cite as 45 Van Natta 333 (1993)

In the Matter of the Compensation of
**STACY W. McMAHAN, Claimant**
WCB Case No. 92-02936
ORDER ON REVIEW (REMANDING)
Doblie & Associates, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Nichols' order which dismissed his request for hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

Claimant requested a hearing in this matter on February 21, 1992. A hearing was originally scheduled for March 10, 1992. That hearing also involved issues which arose from requests for hearing filed on September 11 and September 23, 1991. At the March 10, 1992 hearing, the parties decided to go forward with the hearing only on the issues raised by the September 11 and September 23, 1991 requests for hearing under WCB case number 91-12711. Hearing on this matter, which involves compensability of a cervical condition, was postponed and was assigned WCB case number 92-02936. Hearing was rescheduled for May 26, 1992.

On April 3, 1992, claimant's former attorney withdrew as legal counsel for claimant.

On April 28, 1992, in response to an April 20, 1992 letter from claimant, Referee Howell issued an order in WCB case number 91-12711, which dismissed claimant's requests for hearing filed on September 11, 1991, September 23, 1991 and February 21, 1992. On May 13, 1992, Referee Howell issued an amended order of dismissal which indicated that claimant's April 20, 1992 letter of withdrawal related only to claimant's requests for hearing filed on September 11 and September 23, 1991 and not to his February 21, 1992 request for hearing which had been assigned a separate WCB case number which was being separately litigated. The order reinstated claimant's February 21, 1992 hearing request.

Claimant failed to appear at hearing before Referee Nichols on May 26, 1992. In her order, the Referee noted that the notice of hearing was mailed to claimant at his only known address on March 20, 1992 and that the notice of hearing had not been returned as undeliverable. The Referee dismissed claimant's February 21, 1992 hearing request pursuant to OAR 436-06-071.

On June 4, 1992, the Board received claimant's request for review. In his request, claimant stated that he had failed to appear at hearing because he did not receive notice of the May 26, 1992 hearing.

CONCLUSIONS OF LAW AND OPINION

A Referee shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement of continuance of the hearing. OAR 438-06-071(2). 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 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 Luthy, we treated a post-hearing request to reschedule a hearing as a motion for postponement.

Here, claimant requested review of the Referee's dismissal order, contending that he had not received notice of the May 26, 1992 hearing. Claimant attributed his failure to receive notice of the hearing to changes of his address and confusion caused by his former attorney's withdrawal. Considering claimant's assertions concerning the circumstances which allegedly prevented his appearance at the hearing, we treat his request as a motion for reconsideration of the Referee's order. See Isabel Mendoza-Lopez, 43 Van Natta 2765 (1991); Laurie Frick, 43 Van Natta 2584 (1991). Inasmuch as the Referee did not have an opportunity to rule on claimant's motion, this matter must be remanded to the Referee for consideration of the motion. See Ray Eaglin, 43 Van Natta 1175 (1991).

In reaching our conclusion, we note that our decision should not be interpreted as a ruling either upon the credibility of the representation made by claimant or a finding on whether postponement is warranted. Rather, we find that the Referee is the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Eaglin, supra.

This matter is remanded to Referee Nichols to determine whether postponement of claimant's hearing request is justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the Referee. If the Referee finds that a postponement is not justified, the Referee shall proceed with the issuance of a dismissal order.

We note that claimant submitted a supplemental brief and has attached additional evidence not admitted by the Referee. Because we have already concluded that this matter should be remanded on another basis, we do not address the motion to remand for the taking of additional evidence.

ORDER

The Referee's order dated May 29, 1992 is vacated. This matter is remanded to Referee Nichols for further proceedings consistent with this order.

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February 25, 1993 Cite as 45 Van Natta 334 (1993)

In the Matter of the Compensation of
**RONALD P. OLSON, Claimant**
Own Motion No. 92-0582M
OWN MOTION ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Williams, et al., Defense Attorneys

The claimant requests reconsideration of our January 26, 1993 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The employer is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**IOLA W. PAYNE-CARR, Claimant**
WCB Case Nos. 90-05670 & 91-09641
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

On December 16, 1992, we withdrew our November 17, 1992 Order on Review on our own motion for reconsideration. After conducting our further review, we issue the following order.

On the merits, we adopt the order of the Referee with the following supplementation.

In this medical services dispute case, the record developed and considered by the Medical Director consisted of 226 exhibits, which included medical records and reports from Dr. Berselli, claimant's treating physician. At the hearing before Referee Spangler, claimant sought to supplement the record certified to the Hearings Division by the Director, by offering in evidence, claimant's testimony and seven exhibits. The exhibits consisted primarily of additional chartnotes from Dr. Berselli and letters to or from Dr. Berselli. (See Exs. 227A to 235). The Referee declined to receive the exhibits and claimant's testimony. The question here is whether the Referee erred by that decision.

Claimant does not contend that the Director lacked authority to decide, in the first instance, whether the claimed medical services are reasonable and necessary. Instead, claimant argues, that in confining the scope of review to the record before the Director, the Referee deprived claimant of the right to a full evidentiary hearing on the medical services issue.

Before the 1990 amendments, medical treatment disputes were handled by the Board and its Hearing Division like any other matter concerning a claim. The Hearings Division had original jurisdiction. Board review was de novo. The Director was not involved.

The 1990 amendments transferred decisional authority from Referees and the Board to the Director. The Director now has original jurisdiction. Stanley Meyers, 43 Van Natta 2643 (1991). At the request of either party, the Director may delegate review of the dispute to a panel of three physicians. ORS 656.327(3). Although a party adversely affected by the Director's order may request a hearing under ORS 656.283, amended ORS 656.327(2) provides, in part, that: "[r]eview of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record." (Emphasis added).

Although the legislature's use of the term "hearing" to describe an appellate review function is grammatically incorrect, we find the above quoted language of ORS 656.327(2) plain and unambiguous. Consistent with its purpose to have medical treatment disputes decided by physicians rather than Referees and the Board, the legislature has confined the Referee's scope of review to the record before the Director, and authorized the Referee to modify the Director's order only if the order is not supported by substantial evidence in the record. Invariably, "the record" for purposes of substantial evidence review means the record before the agency or court that is authorized to weigh the evidence. Here that agency is the Director, or the panel of physicians that the Director may appoint pursuant to ORS 656.327(3). Furthermore, an order from this Board authorizing Referees to consider evidence outside that record would revive the state of affairs which had existed before the 1990 amendments by permitting referees or the Board to overrule the Director's decision based on medical evidence that was not provided to the Director. Under our interpretation, any evidence that tends to establish the appropriateness or inappropriateness of the medical treatment at issue should be presented to the Director so that it can be considered by the agency the legislature has chosen to weigh the evidence. Permitting referees and the Board to weigh the evidence anew would defeat the legislature's purpose to have these questions decided by physicians rather than referees.

In reaching this conclusion, we contrast "the record" in hearings conducted under ORS 656.327(2) with "the record" in hearings held pursuant to ORS 656.283(2). A hearing concerning a Director's order regarding vocational assistance (ORS 656.283(2) is designed to determine the historical facts relevant to the dispute). Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992). Since no "record" has been prepared in advance of the hearing in such appeals, it is the responsibility of the Referee when reviewing a Director's order to "make a record." Richard A. Colclasure, 42 Van Natta 2454 (1990).

In contrast, ORS 656.327(2) expressly provides that a Director's order regarding medical treatment may be modified only if the order is not supported by substantial evidence in the record. See also OAR 438-17-010(2). In accordance with this statute, the Board's rules further require the Director to provide the Board's Hearings Division with a certified copy of the entire record, including an index of all items contained in the record. OAR 438-17-020(1). In light of these statutory and administrative directives, it is evident to us that review of a Director's order issued pursuant to ORS 656.327(2) must be based on the record developed before the Director.

Turning to the merits, substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988); Donald J. Bidney, 44 Van Natta 1688 (1992). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990). In order to conduct a substantial evidence review, we must be able to determine what the Director found as fact, and why the Director believed that his findings led to the conclusions that he reached. Armstrong v. Asten-Hill Co., supra at 205.

We find that the Director's order meets this standard. Here, the record contains divergent medical opinions regarding whether the proposed surgery (claimant's sixth arthroscopy) was appropriate medical treatment. Dr. Berselli, the attending physician, felt that the treatment was appropriate, whereas Dr. Donahoo and Dr. Brown (independent medical examiners) disagreed and gave eight separate reasons supporting their opinion that the surgery was inappropriate treatment. Among those reasons was that, based on its temporary nature, a sixth arthroscopic debridement of the patella was not justified after five prior surgical procedures.

After discussing the medical opinions, the Medical Director concluded: "Based upon my review of the records, I concur with the preponderance of opinion found in the record and conclude that the proposed treatment is not appropriate for the worker's current condition." In light of the fact that the Medical Director listed the eight reasons provided by Drs. Donahoo and Brown concerning why the proposed surgery was not justified, we infer from the Medical Director's conclusion that he was persuaded by the opinions of Drs. Donahoo and Brown over the contrary opinion of Dr. Berselli.

Although, the Medical Director did not expressly state that he was relying on the opinion of Drs. Donahoo and Brown, it is apparent from his order that he concurred with their assessment that the proposed surgery was not appropriate. Consequently, we find that the Medical Director's order is sufficient for us to conduct our review.

After conducting our review, we agree with the Referee that the record, viewed as a whole, would permit a reasonable person to find that the proposed treatment was inappropriate. Moreover, such a finding is reasonable in light of countervailing as well as supporting evidence. Therefore, the Director's order is supported by substantial evidence and is affirmed. ORS 656.327(2).

The dissent proposes an interpretation of ORS 656.327 under which referees and the Board would review a Director's findings and order for substantial evidence based on evidence in the record that is submitted to the Referee but which the Director did not have when he made his decision. We continue to believe that the dissent's position is contrary to legislative intent. As previously discussed, the "substantial evidence" test is invariably, an appellate review standard, according to which the appellate forum confines it review to the record made by the agency or court below that had the obligation to weigh the evidence and make findings based on a preponderance of the evidence. Thus, the dissent's position is antithetical to the purpose and function of substantial evidence review.

The dissent also argues that under the majority's interpretation of ORS 656.327 and 656.283, she was denied a meaningful hearing and her due process rights were violated. The dissent contends that the Director conducts no hearing and the Referee's hearing is a meaningless exercise since the Referee cannot provide relief based on facts disclosed at hearing. The dissent relies on Carr v. SAIF, 65 Or App 110 (1983), rev dismissed 297 OR 83 (1984), where the court held that the claimant had a constitutionally protected property interest in temporary total disability benefits and that their payment could not be suspended without an appropriate evidentiary hearing. The present case differs in several important respects. First, claimant has never been eligible for the sixth arthroscopic debridement of the patella that his treating physician wants to perform. To have a legitimate claim of right to the surgery, claimant

bears the burden of establishing that a sixth arthroscopic debridement would be effective and appropriate treatment for his compensable condition. ORS 656.266. Thus, although an injured worker has a lifetime right to reasonable and necessary medical services, claimant here had not yet established at the time of the insurer's denial, that she had a legitimate claim of entitlement to the particular surgical procedure in question. Indeed, whether the surgical procedure is appropriate treatment that should be authorized is the very question that the Medical Director was called upon to decide in this case. See Colclasure v. Washington County School District, 117 Or App 128 (1992) (because claimant had not established his right to vocational assistance, a full evidentiary hearing to consider his claim of entitlement was not required by constitutional law).

Furthermore, the dissent's constitutional and statutory law arguments are predicated on the premise that if a hearing involving witness testimony were required, it is a Referee rather than the Director who must hold the hearing. We believe that the dissent's argument is based on a false premise. Specifically, ORS 656.327 as amended in 1990 carries out the legislature's policy choice to have medical service disputes decided by physicians rather than Referees. Stanley Meyers, supra. To this end, ORS 656.327(2) provides that the Director's decision may be modified by the Referee only if that decision is not supported by substantial evidence in the record. Therefore, if, for any reason, constitutional or otherwise, a duty exists in a given case to receive live witness testimony of documentary evidence, the duty would belong to the Director to receive that evidence before he weighs all the medical evidence and renders a decision. Here, no argument has been made by either party that the Director refused to consider any proferred evidence. Therefore, the constitutional question raised by the dissent (whether an injured worker has the right to a full evidentiary hearing) is actually not presented in this case. In any event, we are unable to conclude from the arguments or from our own research that the procedures established by ORS 656.327 suffer from some constitutional infirmity. Therefore, we must defer to the courts for any further consideration of the dissent's constitutional arguments.

Finally, claimant requests remand, contending that the Referee erred in refusing to allow claimant to develop the record at hearing. Specifically, claimant contends that she should have been allowed to present her own testimony and additional documents from Dr. Berselli, her treating physician, regarding the medical services dispute.

However, inasmuch as the record already contains evidence from Dr. Berselli and we agree with the Referee's conclusion that the Director's order is supported by substantial evidence in the record, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). Accordingly,the request for remand is denied.

Finally, even if we were to consider claimant's testimony and the additional exhibits claimant presented as an offer of proof, our decision would remain the same. Whether claimant should undergo a sixth arthroscopy is obviously a complex medical question beyond the competence of any lay witness, including claimant. The additional exhibits offered are either cumulative of other evidence in the record (Ex. 227B and Ex. 235) or they are immaterial to the question of whether the treatment would be appropriate and effective. (Exs. 227A, 228, 229, 230, 231, and 234).

ORDER

The Referee's order dated February 21, 1992 is affirmed.

**Board Member Kinsley dissenting.**

The majority opinion denies the parties the right to a hearing granted in ORS 656.327(2) for medical treatment disputes arising under ORS 656.327(1)(a). Therefore, I dissent.

Specifically, I disagree that, pursuant to ORS 656.327(2), a "hearing" procedure only requires that a referee review documents sent over from the director, and that a "record" only includes those documents sent over from the director. A "hearing", as that term applies in workers' compensation cases, means the type of event which occurs at the Board's Hearing Division every working day and in which the parties have a right to appear and be heard through a full presentation of evidence in a proceeding before a referee on the "record." A "record," as that term applies in workers' compensation cases, is the record of the proceeding before the referee and includes the evidence that was presented by the parties. Therefore, pursuant to ORS 656.327(2), the parties in this case were entitled to present evidence, other than that received from the director, at hearing before the referee.

ORS 656.327(2) provides as follows:

> "The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS 656.325(1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and findings of the director shall be submitted to the parties within 30 days of the request for review. The findings of the director regarding the treatment in question shall be prepared in such a form and manner and shall contain such information as the director may prescribe. Within 10 days of making the findings, the director shall issue an order based upon the findings. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a hearing on the order. If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record." (Emphasis added).

Statutes are construed in light of all of the language in the entire statute. Tracy v. Employment Div., 29 Or App 851 (1977). In addition, statutes are to be construed in light of all the provisions of the statute bearing on the issue in question. In re Holmlund's Estate, 232 Or 49 (1962). In the present dispute, these guidelines of statutory construction require us to examine the entirety of ORS 656.327(2) and any applicable provisions of ORS 656.283 in construing the specific sentences emphasized above.

ORS 656.327(2) identifies, in chronological order, the steps to be taken in a proceeding involving the review of disputed medical treatment rendered to an injured worker. It begins with a requirement that the director review medical information and records. It does not indicate how that information and those records are to be gathered. Neither does it specifically provide the parties any opportunity to participate in the gathering of the information and records. Following review of medical information and records, the director is required to make findings. Nothing in the statute requires the director to make a "record" upon which those findings are based. The only reference to a record in the statute occurs after the reference to the hearing pursuant to ORS 656.283, a statute which does require the making and reporting of a record. See ORS 656.283(6). The only possible source of the record which the referee is to review in order to determine whether the findings of the director are supported by substantial evidence is the hearing. It is the only time, in the scheme established by ORS 656.327(2), that anyone is required to make a record.

Further, ORS 656.327(2) shows that the form and content of the findings and conclusions of the director are at the discretion of the director. In Armstrong v. Asten-Hill Co., 90 Or App 200 (1988), the Court of Appeals set out the minimum requirements that an agency order must fulfill in order for a substantial evidence review to be accomplished in workers' compensation matters, i.e., the order must contain findings of fact that 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 order. The director's order in this case is exactly of the type that the Court said was inadequate in Armstrong, i.e., it is merely a recitation of evidence followed by a bare conclusion and is devoid of any explanation of why facts supported by evidence lead to its conclusion.

Therefore, given (1) the lack of a requirement that the director make a record, and (2) the lack of standards requiring that the director's order be sufficient to undergo a substantial evidence review, I conclude that the statute does not contemplate that the "medical information and records" gathered by the director along with the director's order are all that may be contained in "the record" for the substantial evidence review referenced in the last line of ORS 656.327(2). Rather, the parties must be allowed to participate in the dispute resolution process by presenting all relevant evidence at a hearing before a referee. It is the totality of this evidence that comprises "the record".

This conclusion, which allows a larger participation by the parties, is further supported by an analysis of what a "hearing" is under ORS 656.327(2). The statute provides that, within ten days of

making the findings, the director is required to issue an order, and it is from this order that any dissatisfied party may request a "hearing". I first observe that, under no known rule of statutory construction can this provision be construed to require that the hearing to which the dissatisfied party is entitled be conducted by, or before, the director. The director's order has already issued at the time the request for hearing is made. So, it is clear that this hearing is to be held before a referee of the Workers' Compensation Board.

The Legislature specified that "[r]eview of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board . . . ." ORS 656.283 sets out hearing rights and procedure. It provides in pertinent part:

> "(3) A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the board.
>
> "(4) The board shall refer the request for hearing to a referee for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party.
>
> "(5) At least 10 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. Hearings shall be held in the county where the worker resided at the time of the injury or such other place selected by the referee.
>
> "(6) A record of all proceedings at the hearing shall be kept but need not be transcribed unless a party requests a review of the order of the referee. Transcription shall be in written form as provided by ORS 656.295(3).
>
> "(7) Except as otherwise provided in this section and rules of procedure established by the board, the 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. . . .
>
> "(8) Any party shall be entitled to issuance and service of subpoenas under the provisions of ORS 656.726(2)(c). Any party or representative of the party may serve such subpoenas."

By specifying that the hearing was to be conducted pursuant to ORS 656.283, rather than some particular subsection, the Legislature expressed its intention that the full protections of ORS 656.283 apply, including the requirements of notice, the right to subpoena witnesses and documents, and to participate in a "hearing". Further, ORS 656.283(7) encompasses the rules of procedure adopted by the Board for contested cases. Our rules of hearing procedure are found at Chapter 438 of the Oregon Administrative Rules. Specific rules pertaining to expedited hearing procedures are found at OAR 438-13. Those administrative rules provide for the right to present lay and medical testimony as well as documentary evidence at the hearing.

By expressing an intention that the hearing be conducted in light of rules adopted by the Board pursuant to ORS 656.283, the Legislature expressed its awareness of the existence and contents of the rules made applicable. See generally State v. Clevenger, 297 Or 234 (1984) (Legislature presumed to have knowledge of decisions of the Supreme Court bearing on an act before them), and State v. Waterhouse, 209 Or 424 (1957) (Legislature presumed to be aware of contents and meaning of prior legislative acts). Given the Legislature's directive that a hearing be conducted pursuant to ORS 656.283, and its specific directive that the hearing occur pursuant to the Board's rules of procedure for expedited cases, the conclusion by the majority that claimant is not entitled to a "hearing" before the Hearings Division, but only a review of the director's medical information and records and the director's order by a referee, is in error.

In addition, the present interpretation of the parties' rights to participate under ORS 656.327(2) could render those provisions unconstitutional. The Court has previously determined that temporary total disability benefits provided pursuant to the Workers' Compensation Law are rights or entitlements sufficient to mandate the requirements of due process. Carr v. SAIF, 65 Or App 110, 118 (1983) rev

dism 297 Or 83 (1984). Here, the claim of entitlement derives from the provisions of ORS 656.245(1)(a) which provides: "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability."

The minimum requirements of due process are notice and an opportunity to be heard. Id. at 118-119. Due process afforded at the minimum level will not be sufficient, however, where the private interest affected is substantial, where the governmental interest is not substantial, and where there is a substantial risk that the procedures afforded will result in an erroneous result. Id. at 119.

In this case, the private interest affected is a claimant's right to receive reasonable and necessary curative medical treatment. Beyond that immediate consideration, there is also the consideration that, if the necessary treatment is not provided, claimant may experience continued disability which can deprive her of the capacity to provide for herself. This is a substantial interest.

The employer's interest in these cases is to pay only for those medical treatments that are reasonable and necessary. Excessive payments can create a financial hardship for employers and, in some cases, affect the employer's capacity to stay in business.

The governmental interest involved is merely the interest in an efficient administrative system and an overall reduction in costs. That interest has already been determined in Carr to be insufficient to preclude pretermination notice and an opportunity to be heard in a situation where a full evidentiary hearing followed, or could follow, loss of benefits That same reasoning would prohibit a complete loss of the opportunity to be heard.

One additional governmental interest is apparent in the legislative history. The Legislature appears to express an interest in having medical questions decided by physicians rather than referees. This might, in fact, be a substantial interest, but it is not necessary to make that determination since, under ORS 656.327, medical questions are not ultimately decided by a physician, but by the director, who has no more medical capacity than does a hearings referee who would also review medical opinions to come to a conclusion and issue an order. In addition, these medical treatment cases often involve substantial legal questions which are not appropriate for medical specialists or the director, and which would be decided without an opportunity to be heard by a referee.

The probability of error is the final consideration. As noted above, legal questions are often involved in medical treatment cases. The probability of an incorrect resolution of these questions absent an opportunity to be heard is significant. In addition, the information upon which the director ultimately reaches his conclusion may be based on an incorrect or inadequate history, upon an incomplete examination or upon any number of factors that would make the evidence unreliable and/or inadmissable in a proper hearing before a referee. These sources of error are readily correctable if the parties have an opportunity to present evidence upon which accurate history and reliable evidence can be determined.

Finally, it appears that if the present decision stands, medical treatment decisions become decisions in "other than a contested case" and, therefore, review is to the circuit courts. See ORS 183.484 and 183.310(2). I can find no evidence that the Legislature intended such a result. Rather than reducing litigation, the Legislature would, for the first time since 1965, allow the circuit courts of this state to become active in substantive issues in workers' compensation cases.

In the end, we have not done the parties a great favor by allowing them a full evidentiary hearing before a referee. The parties must still demonstrate that the director's order is not supported by substantial evidence on the whole record before that order can be modified. That is a heavy burden. Nevertheless, it is a burden which the parties may choose to bear, and it can only be borne, if at all, by permitting the parties an opportunity to fully address the evidence considered by the director, to supplement it, or to challenge its reliability. Because the majority opinion prevents the parties from having that opportunity, I must, respectfully, dissent.

In the Matter of the Compensation of
**KIMBERLY M. SAYLOR, Claimant**
WCB Case No. 91-14284
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Hoguet's order that set aside its denial of claimant's injury claim for a lumbosacral strain. On review, the issue is compensability.

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

Since the Referee's order issued, the court disagreed with our analysis in Bahman M. Nazari, 43 Van Natta 2368 (1991), where we stated that compensability is a two-part test in cases involving preexisting conditions. Tektronix v. Nazari, 117 Or App 409 (1992). Accordingly, we do not adopt the Referee's application of a two-part test in determining whether claimant's low back condition is compensable. In addition, we offer the following analysis.

The Referee found and the parties do not dispute that claimant had a preexisting degenerative disc condition at L5-S1 when she fell at work on July 8, 1991. Nonetheless, the Referee determined that ORS 656.005(7)(a)(B) and its major contributing cause standard do not apply in this case. We agree, but substitute the following analysis.

The medical evidence regarding the causation of claimant's disability and need for treatment following her July 8, 1991 fall at work is provided by Dr. Wilcox, treating chiropractor, and Drs. Neufeld, Coletti and Skei, independent examiners. Dr. Skei, chiropractor, opined that claimant's post-work injury car trip to Montana was the major contributing cause of her low back problems, based on his understanding that claimant had "essentially no problem with her low back" prior to that trip. (Ex. 8-11). However, because claimant's current low back symptoms began with the July fall and did not resolve prior to the Montana trip, Skei's opinion is based on an inaccurate history and we decline to rely on it.

The remaining medical evidence regarding causation is divided. Dr. Wilcox treated claimant conservatively and opined that claimant's preexisting L5-S1 degenerative disc condition was asymptomatic at the time of the July 8, 1991 work injury and remained asymptomatic thereafter. (Ex. 9). Wilcox explained that claimant's fall at work traumatized her lumbosacral and sacroiliac joints and injured her ligamentous structure. (Ex. 7-3). He further explained that prolonged sitting during claimant's subsequent trip to Montana put excessive stress on the injured ligaments, resulting in guarding spasm of supporting musculature, antalgia and considerable pain. (Id). Wilcox concluded that claimant's fall at work was the material cause of her current "acute lumbosacral strain with attendant sacroiliac somatic dysfunction," but the preexisting disc condition was not involved and did not contribute to claimant's symptoms. (Ex. 9).

In contrast, Drs. Coletti and Neufeld, orthopedists, attributed one third of claimant's current low back problem to her preexisting condition, one third to her work injury, and one third to the noncompensable Montana trip. Although Coletti and Neufeld also stated that claimant's preexisting degenerative condition is unrelated to her work injury, we understand their "three cause" conclusion to suggest that three causes combined, resulting in the current low back condition. (See Ex. 8-5-6). However, Coletti and Neufeld do not address Wilcox' opinion that claimant's strain injury involved her muscles and ligaments, but not her degenerative L5-S1 disc. Moreover, because Coletti and Neufeld provide no explanation as to how the injury involved claimant's disc, their conclusion concerning its involvement is not particularly persuasive.

Under these circumstances, we find Wilcox' opinion more persuasive than the others. Based on that opinion, we conclude that claimant's preexisting degenerative disc condition does not contribute to her current low back problems; i.e., it did not combine with the work injury within the meaning of ORS 656.005(7)(a)(B), which, therefore, does not apply. Accordingly, we conclude that claimant has proven a compensable work injury.

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 $600, 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 July 1, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $600, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**KENNETH J. SHORT, Claimant**
WCB Case Nos. 91-09382 & 91-07656
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Darrell L. Cornelius, Attorney
Kathryn Alvey (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The noncomplying employer (NCE) requests review of that portion of Referee Menashe's order that awarded an attorney fee against the SAIF Corporation on behalf of the NCE. In its brief, the NCE also objects to the amount of the attorney fee. The SAIF Corporation waived filing a brief. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last sentence of the fifth full paragraph on page 1. We supplement as follows.

On August 17, 1991, claimant objected to both the NCE's motion to dismiss claimant's request for hearing on its denial and to the withdrawal of the NCE's request for hearing, raising the issue of attorney fees for prevailing on the denial and the request for hearing.

On September 2, 1991, claimant, the SAIF Corporation and the NCE agreed that the attorney fee matter could be decided by the Referee without the necessity of a hearing. The hearing was taken off the docket and the parties agreed to submit written closing arguments, the last of which would be mailed no later than October 7, 1991.

Claimant submitted a Statement of Services in the amount of $2,000.

The Referee made a finding that the request for hearing initiated by the NCE did not result in the disallowance or reduction in claimant's compensation. Based upon ORS 656.382(2), the Referee assessed an attorney fee to be paid by SAIF in the amount of $1,250, as a reasonable fee for services rendered in WCB Case No. 91-07656.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed the matter, based on the withdrawal of the NCE's request for hearing. Nevertheless, upon making the finding that the request for hearing initiated by the NCE did not result in the disallowance or reduction in claimant's compensation, the Referee assessed an attorney fee under ORS 656.382(2), to be paid by SAIF.

The NCE argues that ORS 656.382 does not apply to this case, in that an NCE is not an insurer or self-insured employer; and, citing Strazi v. SAIF, 109 Or App 105 (1991), argues that claimant had not been awarded any compensation that the NCE sought to have reduced or disallowed. We agree that ORS 656.382(2) does not apply to this case, but for different reasons.

In order to support an attorney fee under ORS 656.382(2), claimant must prove that the employer initiated a request for a hearing to obtain a disallowance or reduction in the claimant's award of compensation, that claimant's attorney performed legal services in defending the compensation award, and that the referee found on the merits that the claimant's award of compensation should not be disallowed or reduced. See Strazi v. SAIF, 109 Or App 105 (1991).

Here, the issue of compensability had been withdrawn prior to hearing. Since the compensability issue was no longer before him, the Referee's "finding" that claimant's award of compensation was not disallowed or reduced was not a finding "on the merits" of the claim. When a request for hearing is dismissed without a decision on the merits, the Referee is without authority to award attorney fees under ORS 656.382(2). Strazi v. SAIF, supra; Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990); Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Claude Snow, 42 Van Natta 270 (1990).

Nevertheless, ORS 656.386(1) provides that a reasonable attorney fee shall be allowed if an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held. When, as here, a noncomplying employer requests a hearing on the issue of compensability of a claim and claimant's attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, claimant's attorney is entitled to an attorney fee payable by the SAIF Corporation, as the statutory processing agent for the noncomplying employer, and collectible from the noncomplying employer. Kelly P. Britt, 34 Van Natta 1182 (1982); Edward M. Anheluk, 34 Van Natta 205 (1982); Mary E. Smotherman, 22 Van Natta 182 (1977). We accordingly find that the Referee had authority to award a reasonable attorney fee under ORS 656.386(1).

The NCE also contends that the Referee lacked authority to award attorney fees under amended ORS 656.054(1), which became effective on September 29, 1991, because it applies only to requests for hearing filed after the effective date. We conclude, however, that whether or not the amended statutory provision was applicable, an attorney fee was awardable under ORS 656.386(1). The Referee's award of fees was, therefore, proper.

We next turn to the question of whether the Referee's $1,250 attorney fee award is reasonable. Claimant's attorney submitted a statement of services in which he sought a $2,000 attorney fee for services rendered through September 20, 1991, supported by a written narrative. After considering the factors in OAR 438-15-010(4) and applying them to this case, the Referee awarded $1,250 as a reasonable fee for the attorney's services in defending claimant's right to compensation up to the withdrawal of the request for hearing on August 13, 1991. We affirm the Referee on this issue.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

## ORDER

The Referee's order dated October 16, 1991 is affirmed.

In the Matter of the Compensation of
**ROBERT D. SWINDELL, Claimant**
WCB Case Nos. 91-10136 & 91-09369
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Parker & Bush, Attorneys
Ken Russell (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Safeco, on behalf of Murray Chevrolet, requests review of that portion of Referee Mills' order that set aside its denial of claimant's aggravation claim for a low back condition. Claimant cross-requests review of that portion of the order that declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are aggravation and penalties 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 OPINION

### Aggravation

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

### Penalty and Attorney Fees

The Referee found that Safeco's denial was not unreasonable, based on an MRI that gave rise to the carrier's legitimate doubt as to its liability. We disagree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). To constitute a claim for aggravation, 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), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992). A worsened condition is manifested by either increased symptoms or a worsened underlying condition. See 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). Furthermore, where, as here, permanent disability has been awarded, the worsening must be more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. ORS 656.273(8).

Here, on July 10, 1991, Safeco issued its denial, which stated:

> "We have received information from your attorney indicating that you are claiming an aggravation in reference to your September 20, 1988 on-the-job injury. The only medical information I have is a time loss authorization slip authorizing you to be off work from May 24 through June 2, 1991 and a letter from Dr. Charles Goldberg dated June 17, 1991. Neither of them provide (sic) any objective evidence to substantiate a worsening of your underlying condition over and above that which was reasonably anticipated at the time of your last closure."

Safeco also had in its possession a June 26, 1991, MRI, which indicated that claimant's underlying condition had not changed. This MRI was not accompanied by a medical report.

In the June 17, 1991 letter, Dr. Goldberg, claimant's attending physician, reported that claimant's condition, which included severe low back pain, severe paralumbosacral spasm, reduced range of motion, and numbness in the right thigh extending into the right foot, was more than the usual waxing and waning of his condition. In addition, Goldberg took claimant off his sedentary work, stating: "The patient has definite signs and symptoms and cannot work because of his pain." (Ex. 86).

We conclude that the information available to Safeco supported compensability. Specifically, the letter from claimant's treating physician was sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition had medically worsened beyond the waxing and waning of symptoms of the condition contemplated by the previous 13 percent unscheduled permanent disability award. In addition, review of the Determination Order and the Department's work sheet indicates that no award was made for potentially variable symptoms. Consequently, even if Dr. Goldberg had found claimant's symptoms to be simple waxing and waning, there is no evidence to support the conclusion that claimant received an award in contemplation of it. Dana J. Fisher, 45 Van Natta 225 (1993). Furthermore, we do not find that the MRI, which indicated only that claimant's underlying condition had not changed, and which was not accompanied by a medical report from Dr. Goldberg, was sufficient to provide Safeco with a reasonable doubt as to its liability.

Accordingly, for its unreasonable refusal to pay compensation, Safeco is assessed a penalty equal to 25 percent of all compensation due at the time of hearing, including medical services. Claimant's attorney is awarded one-half of the penalty assessed by this order, in lieu of an attorney fee. Claimant shall receive the remainder of the penalty. ORS 656.262(10); Kim S. Jeffries, 44 Van Natta 824 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over Safeco'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 aggravation issue is $1,000, to be paid by Safeco. 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 October 23, 1991 is affirmed in part and reversed in part. Safeco is assessed a penalty equal to 25 percent of all compensation due at the time of hearing, to be equally divided between claimant and his attorney. The remainder of the order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by Safeco.

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In the Matter of the Compensation of
**BARBARA A. BODELL, Claimant**
WCB Case Nos. 92-02176 & 91-05657
ORDER ON REVIEW
Garlock, Smith & Associates, Claimant Attorneys
Moscato, et al., Defense Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The self-insured employer requests review of Referee Schultz's order that: (1) set aside its denial of claimant's occupational disease claim for her current C5-6 condition; and (2) upheld Liberty Northwest Insurance Corporation's aggravation denial of claimant's 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. We do not adopt the Referee's second Ultimate Finding of Fact.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" on the issues of compensability and responsibility, with the following supplementation.

On review, the employer argues that the Referee should have deferred to the opinion of Dr. Ziven, rather than to the opinion of Dr. Franks. We agree with the Referee that, as claimant's treating physician and the physician who performed claimant's surgeries, Dr. Franks is in the best position to offer an opinion as to causation. We adopt the Referee's reasoning on that issue.

The employer next argues that the Referee incorrectly applied the last injurious exposure rule. Rather, the employer contends that the 1990 statutory changes to the responsibility law apply. See ORS 656.308. We disagree.

Although the initial compensable injury in 1986 may have involved the same body part (i.e., the neck/cervical area) as claimant's current condition involves, claimant's initial problem was at the C6-7 level, and disc changes were not noted at C5-6 until 1988, following an increase in claimant's pain. (Ex. 97). At that time, Dr. Franks reported that although claimant might have problems at C5-6 "potentially down the road," that level was not related to the injury for which he had been treating claimant. (Ex. 97-2).

Under the circumstances, we agree with the Referee that the same condition was not involved. Therefore, ORS 656.308(1) does not apply. See Thomas R. Sauter, 44 Van Natta 102 (1992); Beverly R. Tillery, 43 Van Natta 2470, 2472 (1991).

We agree with the Referee's application of the last injurious exposure rule, and we adopt his conclusions and opinion on that issue. Furthermore, we conclude that the employer cannot shift responsibility to Liberty, as it has not established that work conditions while Liberty was on the risk were the sole cause of the disease, or that it was impossible for work conditions during the period when the employer came on the risk to have caused the disease. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984). We therefore affirm the Referee's conclusion that the employer in its self-insured capacity is responsible for claimant's C5-6 condition.

Claimant's counsel is entitled to an assessed attorney fee for prevailing against the self-insured employer's request for review. See ORS 656.382(2). After considering the factors 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 $950, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the cases (as represented by claimant's respondent's brief), the complexity of the issues and the value to claimant of the interest involved.

ORDER

The Referee's order dated June 2, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $950, to be paid by the self-insured employer.

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February 26, 1993 Cite as 45 Van Natta 346 (1993)

In the Matter of the Compensation of
**HELEN L. DODGE, Claimant**
Own Motion No. 92-0189M
OWN MOTION ORDER ON RECONSIDERATION
Coons & Cole, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our August 13, 1992 Own Motion Order that declined to reopen her claim. On September 11, 1992, in order to fully consider the matter, we abated our prior order and granted the SAIF Corporation an opportunity to respond. After receiving SAIF's response, we asked for further submissions from both parties. After receiving those submissions, and further considering the matter, we issue the following order.

On April 8, 1992, claimant's counsel wrote the Board asking for Own Motion relief. Claimant had been hospitalized from February 14, 1992 through February 18, 1992 for pain management. Claimant's counsel enclosed a February 25, 1992 letter from SAIF to claimant's physician which

"(3) No compensation is due and payable for any period of time where the insurer has requested from the worker's attending physician verification of the worker's inability to work and the physician cannot verify it pursuant to ORS 656.262(4)(b), unless the worker has been unable to receive treatment for reasons beyond the worker's control. Before withholding compensation under this section, the insurer shall inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer shall document its file regarding those findings. The insurer shall provide the department a copy of the documentation within 20 days, if requested. When the verification of temporary disability is received form the attending physician, the insurer shall pay compensation within 14 days of receiving the verification of any authorized period of time loss, unless otherwise denied." (Emphasis added.)

In order to achieve the intent therein, both the statute and the rule assume that the claimant must cooperate with the attending physician and the insurer by providing certain information, in a timely fashion, to ensure that he continues to be eligible to receive benefits for temporary disability. How can the attending physician verify claimant's inability to work if claimant will not contact the physician and/or reschedule an appointment? How can the insurer determine if there is a reason beyond the claimant's control for his failure to receive treatment if the claimant has made himself unavailable and has refused to answer their inquiries?

In this case, there is no evidence that the claimant provided any information or cooperation to either the attending physician or the insurer. The one explanation that the claimant provided for failure to show up for the January 20, 1992 appointment and surgery was found unbelievable by the Referee:

"Although claimant testified that he had understood that his surgery was being cancelled on January 20, 1992, the medical records and Dr. Nash make it quite clear that the surgery was never canceled and claimant just failed to show up at the hospital the morning of the surgery. Based upon my close and careful observation of the claimant and based upon the evasiveness of his testimony and the inconsistencies, I find the claimant to not be believable or credible. I am satisfied that the claimant was fully advised of the surgery and had agreed to the surgery. Apparently, the claimant decided at the last minute that he did not wish to have the surgery and therefore didn't show up at the hospital on January 20, 1992." Opinion and Order at page 3.

I note that the majority did not overturn this credibility finding. Other than this one unbelievable excuse offered on the day of hearing, claimant has offered no evidence explaining why he lost contact with his attending physician and the insurer.

Examination of the record reveals that the insurer called Dr. Nash and learned that claimant had failed to appear for surgery. The insurer immediately called claimant's attorney who responded, "I bet Dr. Nash was pretty upset." At no time did claimant's attorney inform the insurer that claimant was unable to understand the consultation with Dr. Nash. (Tr. 27-29).

Dr. Nash wrote the insurer on January 21, 1992 to inform them that claimant had failed to appear for his hospital appointment the day before, even though the entire procedure was reviewed and the time was verified with claimant only five days earlier. Dr. Nash did not mention authorization of temporary disability benefits. (Ex. 12). The insurer received this letter on January 23, 1992. There is no evidence that claimant contacted Dr. Nash, the insurer or his attorney after he failed to show up for this appointment.

On January 29, 1992, the insurer wrote to claimant. This letter is recited at page 1 of the majority opinion. In addition to the quoted portion, the letter instructed claimant to contact his attorney if he had any questions. It is apparent from the letter that the insurer had been in contact with Dr. Nash and claimant's attorney, that no valid reason was given for claimant's failure to show up for his appointment and that claimant's continued receipt of temporary disability benefits was in jeopardy. (Ex. 13). Claimant personally received this certified letter on January 30, 1992, yet there is no evidence he contacted the insurer, his doctor or his attorney to present himself for another appointment or, if unable to do so, to explain why he was unable to do so.

We are bound by the rules promulgated by the Director insofar as they are consistent with the Workers' Compensation Act, and the authority granted the Director by the Act. Eileen N. Ferguson, 44 Van Natta 1811 (1992) (citing Miller v. Employment Division, 290 Or 285 (1980); Charles M. Anderson, 43 Van Natta 463 (1991)). Here, SAIF does not argue, nor do we find, a conflict between the rule and the substantive provisions of the statute. Rather, we conclude that the Director appropriately promulgated this procedural rule in order to perform his duty to administer the provisions of ORS 656.262(4)(b). Consequently, we are bound by the rule. Ferguson, supra.

For the aforementioned reasons, we conclude that SAIF was not entitled to unilaterally terminate claimant's temporary total disability benefits on the ground that he failed to appear for a scheduled surgery. Consequently, claimant's temporary total disability benefits shall continue until this compensation can be properly terminated by law. Accordingly, we reverse the Referee's order and award temporary total disability from January 20, 1992 until these benefits can be lawfully terminated.

Penalties and Attorney Fees

Claimant contends that SAIF unreasonably terminated his temporary disability, entitling him to penalties and attorney fees. We agree.

Because SAIF failed to make the required inquiries of Dr. Nash and claimant before terminating his benefits, we find the termination to have been unreasonable. Accordingly, a penalty will be assessed, to be equally divided between claimant and his attorney. ORS 656.262(10).

ORDER

The Referee's order dated March 30, 1992 is reversed. Claimant is awarded temporary disability benefits for the period beginning January 20, 1992, until such benefits are terminated according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. SAIF shall pay to claimant a penalty equal to 25 percent of the temporary disability benefits due under this order. Claimant's attorney shall receive one-half of that penalty, in lieu of an attorney fee.

**Board Member Kinsley dissenting.**

I disagree with the majority opinion and would affirm the Referee's order in its entirety.

In my view, the majority misconstrues the relative obligations of the insurer, the attending physician and the claimant required by ORS 656.262(4) and OAR 436-60-020(3).

ORS 656.262(4) provides in relevant part:

"(a) * * * *

"(b) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

"(c) If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment."

OAR 436-60-020(3) provides:

On review, claimant contends that SAIF improperly terminated temporary total disability because it failed to observe the requirements of ORS 656.262(4)(b) and OAR 436-60-020(3). We agree.

ORS 656.262(4)(b) provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

See also Joel O. Sandoval, 44 Van Natta 543 (1992).

Accordingly, we first determine whether SAIF, in fact, requested verification from Dr. Nash regarding claimant's inability to work as a result of his compensable injury. We conclude that SAIF did not.

Claimant last saw Dr. Nash on January 16, 1992, when the arrangements for his surgery were made. Dr. Nash informed SAIF of claimant's failure to appear for surgery on January 20, 1992. On January 29, 1992, SAIF advised claimant that it was discontinuing temporary disability compensation as of January 20, 1992. There is no evidence in the record, however, that before terminating claimant's compensation, SAIF contacted Dr. Nash and requested verification of claimant's inability to work as a result of his injury. Even though we may infer from Dr. Nash's March 5, 1992 letter that SAIF, at some time, contacted him regarding time loss, Nash's letter provided no reason for his statement that "time loss has not been approved." Further, SAIF's attorney specifically represented at hearing: "[T]he reason [Dr. Nash is not approving time loss] is because of claimant's lack of cooperation." (Tr. 14).

Thus, there is no evidence that Dr. Nash's refusal to approve time loss was due to claimant's inability to work as a result of his injury. Neither is there other evidence of a change in claimant's inability to work. Further, on February 27, 1992, SAIF demanded that claimant schedule surgery in order to reach maximum recovery and become medically stationary. This demand belies any assumption that claimant's condition had changed. Under these circumstances, we conclude that SAIF did not satisfy the requirements of ORS 656.262(4)(b) prior to terminating claimant's compensation.

Claimant also argues that SAIF failed to follow the dictates of OAR 436-60-020(3), which require an insurer to inquire of the worker, before withholding compensation, whether a reason beyond the worker's control prevented him from receiving treatment. SAIF first contends that claimant failed to carry his burden of proving this issue because he presented no evidence at hearing regarding what actions were or were not taken by SAIF.

We agree that the burden of proof is on claimant. ORS 656.266. Presuming, however, that SAIF fully disclosed all documents pertaining to this claim as required under OAR 438-07-015, we infer that SAIF did not make the required inquiry. We accordingly conclude that claimant met his burden of proof on this issue.

SAIF then argues that because ORS 656.262(4)(b) does not require the insurer to contact the worker prior to terminating benefits, the requirements of the administrative rule exceed the statute and are not enforceable. We disagree.

The Director may make and declare all rules which are reasonably required in the performance of these duties. ORS 656.726(3)(a).

OAR 436-60-020(3) states in relevant part:

> "Before withholding compensation under [ORS 656.262(4)(b)], the insurer shall inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer shall document its file regarding those findings."

"It is up to you to continue seeking treatment with a medical service provider. Further time loss benefits will not be paid without authorization from your attending physician."

On February 27, 1992, SAIF advised claimant that pursuant to ORS 656.325 and ORS 436-60-105, it would ask for suspension of benefits if claimant, his attorney, or Dr. Nash did not indicate a new date for surgery by March 9, 1992.

On March 5, 1992, Dr. Nash wrote the following:

"[Claimant] has been released from my care on January 20, 1992.

"Time loss has not been approved and the patient has been advised from Saif Corporation he is to be treated by a Caremark physician."

SAIF discontinued time loss payments as of January 20, 1992. (Ex. 15-1).

## FINDINGS OF ULTIMATE FACT

Prior to discontinuing time loss, SAIF did not request verification from claimant's attending physician regarding claimant's inability to work resulting from his compensable injury, nor did it inquire of claimant whether he was unable to receive treatment for reasons beyond his control.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

Claimant submitted as an appendix to his brief an order from the Workers' Compensation Division, dated April 2, 1992, in which the Department denied SAIF's request to suspend compensation pursuant to ORS 656.325. In its brief, SAIF moved to strike those portions of claimant's brief referencing the document and the document itself as being outside the record, irrelevant to the issues in this case, and as possibly being subject to litigation.

On review, we are limited to the record developed at hearing. ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). We may, however, take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2). We have previously taken official notice of determination orders and prior approved stipulations on a claim. E.g., Grace B. Simpson, 43 Van Natta 1267 (1991); Rita M. Duncan, 42 Van Natta 1854 (1990).

The Department's order in this case is an act of a state agency, which is expressly subject to judicial notice under ORS 40.090(2). See Rodney J. Thurman, 44 Van Natta 1572, 1573 (1992). Therefore, we take official notice of the order's existence and deny SAIF's motion to strike. We conclude, however, that the order has very limited relevance to the issue before us.

The issue is SAIF's termination of temporary disability benefits under ORS 656.262(4)(b). (Tr. 8). The Department's order, on the other hand, is an Order Denying Suspension of Compensation Pursuant to ORS 656.325, which requires consent of the Director prior to suspension of compensation. Because the issue of the suspension of compensation under ORS 656.325 is not before us, the document has little probative value in our review.

### Temporary Total Disability

The Referee concluded that SAIF was permitted by ORS 656.262(4)(b) to terminate temporary total disability payments as of the date claimant failed to appear for scheduled surgery, based on the failure to appear and Dr. Nash's refusal to approve any further time loss compensation. In addition, the Referee inferred that claimant had become medically stationary as a result of the refusal to approve further time loss.

is, in the event that it is subsequently resolved that claimant's hospitalization is causally related to her compensable injury and that her hospitalization is appropriate, we authorize the payment of temporary disability compensation beginning from the date of hospitalization. Such compensation shall continue until claimant is medically stationary, at which time SAIF shall close the claim pursuant to OAR 438-12-055.

Claimant's attorney is allowed an approved fee in the amount of 25 percent of any increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. OAR 438-15-010(4); 438-15-080.

Finally, we again emphasize that as long as the parties' dispute remains unresolved, no temporary disability compensation is authorized by this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**EFRAIN C. ESPINOZA, Claimant**
WCB Case No. 91-17966
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Hooton and Kinsley.

Claimant requests review of those portions of Referee Peterson's order that: (1) upheld the SAIF Corporation's termination of temporary disability compensation; and (2) declined to award a penalty and attorney fee for an allegedly unreasonable unilateral termination of temporary disability compensation. Claimant has provided an additional evidentiary document regarding this matter which he requests that we include in our review. In its brief, SAIF moves to strike those portions of claimant's brief referencing the document and the document itself. On review, the issues are motion to strike, unilateral termination of temporary disability compensation and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact through the third sentence of the first full paragraph on page 2; and the second full paragraph on page 2, with the exception of the last sentence. We supplement as follows.

The surgery recommended was an L4-5 diskectomy and bilateral foraminal decompression.

On January 21, 1992, Dr. Nash informed SAIF that claimant had failed to report for his scheduled surgery.

On January 29, 1992, SAIF wrote to claimant as follows:

> "Pursuant to ORS 656.262(4)(b) and OAR 436-60-020(3)(4)(a)(b)(c), this letter is to advise you of your termination of your time loss benefits, effective January 20, 1992. SAIF Corporation has received no further authorization for time loss benefits after your failure to submit to surgery by Dr. Nash, as scheduled on January 20, 1992.
>
> "Information received from Dr. Nash's office and your attorney provides no valid reason for your failure to show for the January 20, 1992 scheduled surgery. You were in their office on January 16, 1992 where all plans for the surgery were discussed.
>
> "If your plans are to change your attending physician, we will require you to select a Caremark Comp Medical Provider. I have provided a Caremark Comp Medical Provider directory from which to select a new attending physician.

indicated that SAIF was disapproving his request for palliative care on the basis that: (1) claimant was not working, therefore, palliative care was not necessary to maintain employment; (2) there were insufficient objective findings to document claimant's need for care; (3) the request for care was excessive, inappropriate, and unnecessary; and (4) the palliative care was unrelated to the accepted injury. The letter also indicated that the physician could request approval for the care from the Director.

Following a series of Board requests for information, claimant's counsel advised the Board that SAIF had refused to authorize palliative care resulting in claimant's hospitalization. Contending that SAIF's failure to authorize palliative care had caused claimant to leave work again, counsel noted that SAIF would not respond with either authorization or denial of palliative care and claimant's physican was becoming "intimidated."

On August 13, 1992, we issued an order denying claimant's request for reopening. We reached this conclusion because the record did not establish a relationship between claimant's need for hospitalization and her compensable injury. On August 17, 1992, claimant's counsel responded, arguing that the claim was compensable because SAIF had not issued a denial. Counsel also stated that, had SAIF contested the appropriateness of the treatment, claimant would have requested Director review. Treating this notification as a request for reconsideration, we issued a September 11, 1992 Order of Abatement.

On September 22, 1992, SAIF advised the Board that it was in the process of determining its responsibility by scheduling claimant for an October 10, 1992 independent medical examination. SAIF also stated that should claimant's condition be determined to be compensable, it would still contend that the hospitalization was excessive and unnecessary treatment. On December 17, 1992, staff counsel wrote the parties requesting that, within 14 days from the date of the letter, SAIF provide either a copy of its formal denial or a copy of a request for Director's review. Counsel noted that in the event that neither a denial or a request for Director's review was forthcoming, the Board would consider reopening claimant's claim contingent upon the resolution of the parties' dispute. To date, no further response has been received.

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). As the emphasized language indicates, our authority to award temporary disability compensation is limited to situations where the criteria of ORS 656.278(1)(a) are satisfied. However, under the current version of the Workers' Compensation Act, the jurisdiction to resolve certain disputes, which would have an impact on whether the criteria of ORS 656.278(1)(a) have been satisfied, rests elsewhere.

For example, jurisidiction to resolve disputes regarding causation, rests with the Hearings Division. ORS 656.283(1); Michael A. Jaquay, 44 Van Natta 173 (1992). Similarly, jurisdiction to resolve disputes, with regards to the appropriateness of the treatment, rests with the Director. ORS 656.327; Stanley Meyers, 43 Van Natta 2643 (1991). Where there is a dispute involving matters not within the Board's own motion jurisdiction, it has been the Board's policy to postpone action on a request for Own Motion relief until pending litigation is resolved. This policy, however, assumes that the parties have availed themselves of the litigation processes provided for in Chapter 656.

Here, there is a dispute between the parties that is not within the Board's own motion jurisdiction. Specifically, SAIF's September 22, 1992 letter advised the Board that it was contesting the compensability and appropriateness of claimant's hospitalization. Notwithstanding this dispute, neither party has instituted litigation under either ORS 656.283(1) or ORS 656.327. As noted above, our authority to grant temporary disability compensation is contingent upon the criteria set forth in ORS 656.278(1)(a). However, as a result of the parties' dispute and current positions, it remains unresolved whether claimant's hospitalization was causally related to the compensable injury, or whether the hospitalization was appropriate treatment. Therefore, we are unable to authorize the payment of temporary disability compensation at this time.

Nonetheless, we decline to leave the parties in a perpetual state of limbo, particularly when a practical solution is available. Therefore, under these specific and limited circumstances, we consider it appropriate to authorize the payment of temporary disability compensation on a contingent basis. That

Here, the history Dr. Thomas relied on in determining a work relationship is actually consistent with the statement given to the employer and to the insurer's investigator soon after the incident. Furthermore, claimant's testimony that he lifted a heavy cart ("bunk") onto tracks on June 18, 1991, was verified by the unrebutted testimony of a co-worker. The fact that claimant did not complain of pain to the co-worker is consistent with claimant's testimony about the development of pain some time after the incident. In addition, although claimant did not immediately correlate the lifting incident with his back pain, Dr. Thomas found back pain, tenderness, muscle spasm and limited flexion on claimant's first visit.

The videotapes, made months after the June 18, 1991 injury, do not go to the issue of the compensability of that original injury. Furthermore, there is nothing in the videotapes that is inconsistent with the indications to claimant by Drs. Kendrick and Stewart that he would not injure himself by doing the work necessary to run his cattle, work to which they released him prior to the videotaping.

Accordingly, we conclude that claimant experienced a compensable injury to his low back in the course and scope of his employment.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated December 23, 1991 is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded a reasonable assessed attorney fee of $2,500, payable by the insurer.

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In the Matter of the Compensation of
**BRIAN M. LUNDQUIST, Claimant**
WCB Case No. 91-14573
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of Referee Houget's order that: (1) found that an unappealed March 1988 denial of claimant's claim for right carpal tunnel syndrome has no preclusive effect on claimant's present occupational disease claim for the same condition; and (2) set aside its denial of claimant's right carpal tunnel syndrome claim. In his brief, claimant objects to the Referee's exclusion of Exhibit 5A. On review, the issues are res judicata, compensability, and evidence. We reverse.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not his "Ultimate Findings of Fact." In addition, we supplement with the following.

Claimant did not appeal the employer's March 21, 1988 denial of his claim for right carpal tunnel syndrome. That denial has become final by operation of law.

Claimant works as a full-time substitute bus driver for the employer. In addition to being paid for the time he drives, claimant is paid from the time he reports to work to await an assignment. Since 1988, claimant has been driving buses with power steering about 85 percent of the time. The buses are equipped with seat weight springs that must be adjusted according to the differing weights of the drivers. Claimant has to adjust a seat spring on the average of once or twice a day. This task requires turning a knob for two to three minutes.

We find that the entire record establishes that claimant was unable to do her regular work or the modified work to which she was released at the time she quit. We also find that claimant quit because of the increased pain caused by the modified work and was disabled due to the compensable injury from April 11, 1991 through September 24, 1991, the date she became medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, supra.

Claimant is entitled to an assessed attorney fee for prevailing over the 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 temporary total disability 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.

## ORDER

The Referee's order dated April 29, 1992, as corrected on May 1, 1992, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750 to be paid directly to claimant's attorney by the self-insured employer.

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In the Matter of the Compensation of
**JON S. LORANGER, Claimant**
WCB Case No. 91-13568
ORDER ON REVIEW
Borneman & Rossi, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

On June 18, 1991, claimant lifted one side of a bunk which is a heavy, four-wheeled car that runs on tracks and on which lumber is stacked, to place it back on its track. At the time of the lift, claimant experienced over exertion of his low back muscles, but no pain. By the end of his shift, claimant's low back became stiff and painful.

Dr. Thomas found bilateral tenderness, muscle spasm and reduced flexion in the low back. He treated claimant conservatively. By July 1, 1991, Dr. Thomas suspected possible disc disease and arranged for claimant to be evaluated by Dr. Eckman, neurologist.

Dr. Eckman found significant flattening of the lordotic curve and paravertebral muscle spasm in the lumbar area, as well as degenerative disc disease at L4-5 and L5-S1 with a small disc protrusion at L5-S1.

## CONCLUSIONS OF LAW AND OPINION

Claimant has the burden to prove by a preponderance of the evidence that he injured his back in the course and scope of his employment.

The Referee determined that claimant's testimony was not credible, based on inconsistencies between statements given to an investigator in July 1991 concerning the first appearance of pain, and surveillance films taken in July and August 1991. We defer to the Referee's finding when based on claimant's demeanor. However, when the determination is based on an objective evaluation of the substance of a witness' testimony, the Referee has no greater advantage than the reviewing body in determining credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). The Referee made no demeanor finding. Accordingly, we conclude that he based his conclusion on his evaluation of the substance of claimant's testimony.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant proved entitlement to temporary total disability from April 11, 1991 through September 24, 1991. We agree.

The employer argues that claimant's procedural entitlement to temporary disability is governed by ORS 656.268(3) and former OAR 436-30-036. Citing former OAR 436-30-036(4)(f) and (g), the employer argues that claimant is not procedurally entitled to temporary disability because, it asserts, claimant quit working for reasons unrelated to her compensable injury and no attending physician authorized time loss.

However, because claimant's claim has been closed, the issue is not procedural entitlement to temporary disability but substantive entitlement. Although a claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. See Esther C. Albertson, 44 Van Natta 2058 (1992). Rather, a claimant's substantive entitlement to temporary total disability is determined at claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Therefore, the employer's argument that claimant is not entitled to temporary disability solely because no attending physician explicitly authorized time loss is without merit.

The employer also argues that claimant is not entitled to temporary disability benefits after April 10, 1991 because she quit working for reasons unrelated to her compensable injury, namely that she disliked the modified deli job, and withdrew from the work force. We disagree. There is no question that claimant disliked the deli job and wanted to return to the seafood job, which was beyond her physical capacity. However, we find that claimant left work as a result of her compensable injury.

Claimant credibly testified that she quit work, not because she did not like the deli work, but because she was in a lot of pain from her compensable cervical injury and felt that she could not handle it anymore. (Tr. 11). She also testified that her last modified job of facing shelves effected her neck, shoulder and back areas because of the bending and twisting required. (Tr. 9). These statements are supported by the record.

Although claimant repeatedly complained that she did not like the modified deli job, she also reported to her vocational counselor that the modified shelf-facing job "caused her increased shoulder and neck discomfort and she felt that the position was inappropriate." (Ex. 48-2, -3). When claimant quit work on April 10, 1991, she was assigned to the shelf-facing job.

On May 17, 1991, claimant was examined by Dr. Andresen, a physician specializing in rehabilitation medicine who eventually became her treating physician. Dr. Andresen observed video tapes of the seafood clerk, deli clerk, and shelf-facing jobs. (Ex. 53-1). He opined that only the shelf cleaning job appeared within claimant's physical capacities but suspected claimant's pain would increase to a point that she could not do that job. Id. This observation supports claimant's testimony that she was unable to do the shelf-facing job due to increased pain. Dr. Andresen also noted that claimant could not tolerate light duty work at that time. (Ex. 54-6, -7). Dr. Andresen later confirmed these opinions, stating that it would have been appropriate to totally remove claimant from the seafood clerk, deli clerk, and shelf facing jobs. (Ex. 70-2).

We note that Dr. Golden, claimant's treating surgeon, essentially deferred to Dr. Andresen's opinion regarding claimant's ability to work. On March 29, 1991, in response to correspondence from claimant's vocational counselor and a call from claimant stating that she had more arm pain and could not work, Dr. Golden opined that he could not make a judgment about claimant's work capacity without additional professional help and referred claimant to Dr. Andresen. (Ex. 46). At that time, Dr. Golden opined that claimant could perform light duty work, although he noted that the seafood and deli jobs were not light duty. Subsequently, claimant became unable to perform light duty work, as shown by Dr. Andresen's reports. (Exs. 53, 54, 70).

Although Rocha concerned temporary disability and this case involves permanent disability, we find that the holding in Rocha is applicable to this case. When the employer here requested review of the prior Referee's order finding the claim compensable, it was entitled to stay payment of "the compensation appealed" including any permanent disability to which claimant would be entitled. To do otherwise would nullify the employer's entitlement to stay compensation pursuant to the statute. Therefore, we conclude that the employer properly stayed payment of the permanent disability award provided by the Determination Order.

Rate of Scheduled Permanent Disability

Although the Referee found that the employer properly stayed payment of the scheduled permanent disability award, he also found that the award should be paid at the rate of $305 per degree, relying on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991). The employer cross-requests review of this portion of the Referee's order.

Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992). Here, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. Id. Therefore, in the event that the scheduled permanent disability award becomes payable, claimant is entitled to be paid at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Penalties and Attorney Fees

Claimant also challenges the Referee's refusal to award a penalty or attorney fee based on the employer's stay of payment of the compensation awarded by the Notice of Closure and Order on Reconsideration. Claimant also asserts that he is entitled to a penalty based on the employer's failure to pay the scheduled permanent disability award at the rate of $305 per degree. Having found that the employer properly stayed payment of the permanent disability award and that claimant is not entitled to be paid at the rate of $305 per degree, the employer's conduct was not unreasonable and claimant is not entitled to a penalty or related attorney fee.

ORDER

The Referee's order dated May 18, 1992 is reversed in part and affirmed in part. We reverse those portions of her order directing the employer to pay the scheduled permanent disability award at $305 per degree and awarding an approved fee out of the additional scheduled permanent disability created by the increased rate. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**MARY A. LOCKWOOD-PASCOE, Claimant**
WCB Case Nos. 92-03912 & 91-09410
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Nichols' order that affirmed the February 24, 1992 Order on Reconsideration which awarded additional temporary total disability from April 11, 1991 through September 24, 1991. On review, the issue is temporary total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. After claimant cut her finger while working at the modified deli clerk job, she was released by the Emergency Room physician to perform light duty work which consisted of facing shelves and washing the fronts of freezers. (Ex. 47-1). This shelf-facing job increased claimant's shoulder and neck pain. (Tr. 9, Ex. 48-2).

In the Matter of the Compensation of
**DALE E. HOLDEN, Claimant**
WCB Case No. 91-16867
ORDER ON REVIEW
Olson, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Myzak's order that: (1) found that the self-insured employer properly stayed payment of scheduled permanent disability awarded by a Notice of Closure and Order on Reconsideration; (2) declined to award a penalty or attorney fee based on the employer's allegedly unreasonable conduct in staying payment of permanent disability; and (3) declined to award a penalty or attorney fee for the employer's allegedly unreasonable conduct in failing to pay claimant's scheduled permanent disability award at the rate of $305 per degree. The 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 stay of compensation, rate of scheduled permanent disability, and 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.

On September 30, 1992, the Court of Appeals affirmed the Board's order affirming a Referee's order that set aside the employer's denial of claimant's right knee injury claim.

## CONCLUSIONS OF LAW AND OPINION

### Stay of Payment of Compensation

In a prior proceeding, a Referee set aside the employer's denial of claimant's right knee injury claim. The employer requested Board review. The Board affirmed the Referee's order, and the Court of Appeals affirmed the Board's order. Prior to the Board's order, a Notice of Closure issued awarding 12 percent scheduled permanent disability. After claimant requested reconsideration, an Order on Reconsideration reduced the award to 6 percent scheduled permanent disability. Both the employer and claimant requested a hearing from the Order on Reconsideration. The employer stayed payment of the compensation awarded by the Notice of Closure and Order on Reconsideration.

The Referee affirmed the 6 percent scheduled permanent disability awarded by the Order on Reconsideration and further found that, because the prior proceeding concerning compensability of the claim had been on appeal to the Board and Court of Appeals, the employer properly stayed payment under ORS 656.313(1) of the scheduled permanent disability awarded by the Notice of Closure and Order on Reconsideration. Claimant objects to the Referee's conclusion that the employer properly stayed payment of the permanent disability award.

ORS 656.313(1)(a) provides that "[f]iling 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[.]" In Carol D. Goss, 43 Van Natta 2637, 2639 (1991), the Board held that the statute applied only to a carrier's appeal from the order which awarded the compensation in dispute. Therefore, the Board found that the employer did not lawfully stay compensation awarded by a Determination Order on the basis that it had requested review of a prior Referee's order that found the claim compensable. Id.

However, we recently reexamined the holding in Goss in Felipe A. Rocha, 45 Van Natta 47 (1993). Based on the language in ORS 656.313(1), we held that a carrier is entitled to stay the payment of "pre-litigation" temporary disability, or temporary disability accruing before the issuance of an order by a Referee or the Board finding the claim compensable, pending its appeal of the order regarding compensability, regardless of whether a Determination Order had awarded "prelitigation" temporary disability. To the extent that this holding was inconsistent with Goss, the Goss holding was disavowed.

On February 27, 1992, the insurer again wrote to claimant and warned him that they would ask for suspension of his benefits due to his failure or refusal to remain under a physician's care. The insurer requested that claimant, his attorney or Dr. Nash contact them by March 9, 1992 with a new date for surgery. (Ex. 14). Even though the letter was sent to claimant by both regular and certified mail, there is no evidence that claimant contacted the insurer, Dr. Nash or his attorney to set up a reappointment or, if unable to do so, to explain why he was unable to do so.

On March 5, 1992, Dr. Nash wrote that he released claimant from his care as of January 20, 1992 and that he had not approved temporary disability benefits. (Ex. 16).

It is apparent from the above that the insurer attempted to contact the claimant, either personally or through claimant's attorney, and that claimant never responded to the insurer, Dr. Nash or his attorney. It is hard to understand why claimant should profit from his refusal to cooperate and failure to give information.

I find that the insurer substantially complied with the requirements of ORS 656.262(4)(b) and OAR 436-60-020(3) in that claimant had ample notice that he needed to stay in contact to keep his temporary disability checks coming in every two weeks. Further, it is undisputed that claimant did not have verification of his inability to work after January 20, 1992 and that there is no evidence that he was unable to receive medical treatment for reasons beyond his control. Until such medical verification is received or until credible "reasons beyond the worker's control" are provided, claimant should not be awarded benefits for temporary disability benefits beyond January 20, 1992.

Although I find that claimant is ineligible to receive temporary disability benefits after January 20, 1992 pursuant to ORS 656.262(4)(b), there could be a somewhat different result if ORS 656.262(4)(c) is found to be controlling. One reading of that statute may be that benefits could not be discontinued until the claimant failed to show up for a reappointment. Here, the insurer gave a time limit of March 9, 1992 for a reappointment (Ex. 14). It is undisputed that claimant did not call or appear for any reappointment. Therefore, under subsection (c), the insurer was entitled to stop payment of temporary disability payments after March 9, 1992.

While I agree with the majority opinion's conclusion that an insurer may not unilaterally terminate a claimant's temporary disability benefits solely on the ground that he failed to appear for scheduled surgery, I conclude that claimant's failure to appear for the surgery combined with (1) his failure to cooperate and respond to his physician and the insurer, (2) his failure to call or appear for a reappointment, (3) his failure to provide credible reasons that failure to receive treatment was beyond his control, and (4) the lack of medical verification of inability to work after January 20, 1992, provide adequate grounds for termination of benefits.

For the above reasons, I respectfully dissent.

Dr. MacKay is claimant's attending physician for his workers' compensation claim. Claimant was treated by Dr. MacKay on May 14, 1991 and February 13, 1992 for his right carpal tunnel syndrome.

At hearing, claimant sought to submit Exhibit 5A, an investigative report prepared by the employer's claims processing agent. The employer objected to the submission of this document on the grounds that it was untimely submitted and constituted hearsay. The Referee sustained the employer's objection and declined to admit Exhibit 5A.

Claimant's work activities for the employer are not the major contributing cause of his right carpal tunnel syndrome.

Claimant's right carpal tunnel syndrome has not pathologically worsened since March 1988.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

The Referee excluded Exhibit 5A, an investigative report prepared by the employer's claims processing agent, on the ground that the document constituted hearsay. On review, claimant argues that the exhibit should have been admitted as it was allegedly timely submitted, or as admissions by a party opponent, or because it was not submitted for the truth of the matter asserted.

Assuming without deciding that Ex. 5A constituted hearsay, we conclude that substantial justice allows its admission into the record. ORS 656.283(7) provides that "the referee is not bound by common law or statutory rules of evidence . . . and may conduct the hearing in any manner that will achieve substantial justice." Evidence is not deemed inadmissible solely on the basis that it is hearsay. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498, 501 n.2. Exhibit 5A consisted, in part, of statements claimant, the employer's station manager, and assistant station manager made to the employer about difficulties with the bus seat adjustment knob. Thus, they were of probative value and, we conclude, should have been admitted. Since the exhibit is already present in the record, we consider it in our review. Herbert D. Rustrum, 37 Van Natta 1291 (1985).

With regard to the timeliness of the exhibit's submission, we note that claimant's counsel added this document to the record on the same day he received the employer's exhibit list. After our review of the relevant rules, OAR 438-07-015 and OAR 438-07-018, we find that the exhibit was submitted in a timely fashion.

### Res Judicata

The Referee found the employer's unappealed March 1988 denial of claimant's claim for a right carpal tunnel syndrome has "no effect whatsoever" on claimant's present occupational disease claim for the same condition. On review, the employer argues that claimant is barred by res judicata from obtaining compensation for the right carpal tunnel syndrome (CTS) unless he can prove that the condition has changed since the 1988 denial. We agree.

Res judicata, or "preclusion by former adjudication," precludes relitigation of claims and issues that were previously adjudicated. Drews v. EBI Companies, 310 Or 134, 139 (1990); North Clackamas School District v. White, 305 Or 48, modified 305 Or 468 (1988). Similarly, an unappealed denial bars future litigation unless the condition has changed and claimant presents new evidence to support the claim that could not have been presented earlier. See Liberty Northwest Insurance Corporation v. Bird, 99 Or App 560 (1989).

Claimant argues that there was no claim in 1988 because the CTS did not necessitate medical treatment or result in time loss from work. However, the record reflects that claimant filed an 801 Form on January 21, 1988. He identified his injury or disease as possible carpal tunnel syndrome affecting the right hand -- "caused by my driving Transit Bus." The employer's March 1988 denial specifically advised claimant that his CTS claim was not compensable and, thereby, put claimant on notice that he must act on the denial to preserve his right to compensation for that condition. Claimant did not appeal, and that denial has become final by operation of law.

Thus, claimant's right CTS condition became not compensable as of the 1988 denial. The current claim, therefore, is properly characterized as a claim for a worsening of a preexisting noncompensable condition. See Duane A. Alioth, 44 Van Natta 216 (1992); Anna M. Turner, 41 Van Natta 1956 (1989). Therefore, in order to establish the compensability of his right CTS as an occupational disease, claimant must prove by a preponderance of the evidence that his work activities after March 1988 are the major contributing cause of a pathological worsening of his preexisting condition. ORS 656.802(2). See Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979).

Compensability

For his preexisting right CTS to be found compensable, claimant must establish both that his condition is causally related to his work, and that the condition has worsened. Although claimant's opinion is probative, the causation of his condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Claimant relies on the opinion of consulting physician Dr. Long, who opines that claimant's work as a bus driver is the major contributing cause of the development of his "upper extremity conditions." The insurer relies on the opinion of independent examining physician Dr. Button, who believes that claimant's CTS condition is idiopathic. Dr. MacKay, claimant's treating physician, concurs with Dr. Button's opinion.

When there is a dispute between medical experts, greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986). Dr. Button took a "detailed description" of claimant's work and off-work activities and conducted a thorough examination. He noted that CTS is a condition which is seen in all ages and both sexes, and that there is not a strong occupational relationship between bus driving and CTS. Dr. Button explained that claimant does not have to exert a "sustained repetitious power grip with twisting," because he drives mostly buses equipped with power-assisted steering which require little force to control. Further, Dr. Button noted that in turning a bus, the turning forces occur through the shoulder and elbow, rather than through the wrist and hand. Because he could not identify preexisting or underlying medical conditions commonly associated with CTS, Dr. Button opined that claimant's CTS is idiopathic in origin. Dr. MacKay, to whom claimant also gave a complete description of his job duties, concurred with Dr. Button's report. We find Dr. Button's opinion to be well-reasoned and based on complete information. Accordingly, we find it most persuasive and give it the most weight.

We give less weight to the opinion of Dr. Long, who acknowledges that claimant's work does not involve repetitive and strenuous wrist movements such as are required to cause traumatic CTS. He does not identify specific work activities that claimant performed that could cause CTS. Instead, Long opines that claimant's "total work exposure" as a bus driver was causative. Long's lack of specificity detracts from his opinion which, moreover, appears to be based, in part, on his consideration of claimant's other upper extremity symptoms not subject to this claim. In this regard, Dr. Long notes that claimant has right CTS and myofascial pain of the right forearm flexors and extensors, yet he offers only one inclusive opinion on causation -- that claimant's work as a bus driver is the major contributing cause of the development of his "upper extremity conditions."

Neither has claimant established a pathological worsening of his preexisting noncompensable CTS since the March 1988 denial. Both Drs. Long and Button note only that claimant experienced a recurrence of symptoms in early 1991. Neither physician has opined that claimant's underlying condition has worsened since March 1988.

Based on Dr. Button's opinion, as concurred in by Dr. MacKay, we find that claimant has not proven that work activities for the employer after March 1988 either caused or worsened his right carpal tunnel syndrome. Consequently, we reverse the Referee's order. The Referee's attorney fee award is also reversed.

ORDER

The Referee's order dated June 25, 1992 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award of $2,200 is also reversed.

In the Matter of the Compensation of
**RALPH T. MASUZUMI, Claimant**
WCB Case No. 91-17768
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Phillip L. Nyburg, Defense Attorney

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Black's order that upheld the insurer's denial on the basis that claimant's hearing loss claim was not timely filed. Claimant asserts that his claim was timely filed and that he proved the compensability of his claim. On review, the issues are timeliness and compensability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness

ORS 656.807(1) provides:

> "All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:
>
> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
>
> "(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

Here, claimant argues that he was not informed by his physician that he was suffering from an occupational disease until August 5, 1991. Because he filed his claim on September 18, 1991, he argues that he satisfied the one-year time limit in ORS 656.807(1). See Bohemia Inc. v. McKillop, 112 Or App 261 (1992).

In order for a physician to inform a claimant that he is suffering from an occupational disease under the statute, the physician must have told the claimant "simply and directly that his disease arose out of his employment." Liberty Northwest Ins. Corp. v. Meeker, 106 Or App 411, 414-15 (1991); Templeton v. Pope and Talbot, Inc., 7 Or App 119 (1971). Claimant's treating physician, Dr. Scott, otolaryngologist, spoke to claimant on three occasions regarding his hearing loss. On December 21, 1989, Dr. Scott told claimant that he had a "significant hearing loss and noise exposure is indeed one of the causes of this type of hearing loss." (Ex. 8-1). Although Dr. Scott also advised claimant to wear hearing protection and that any additional hearing loss could necessitate a job change, there is no evidence that Dr. Scott told claimant his hearing loss was caused by his job.

Claimant again saw Dr. Scott on July 30, 1990. Dr. Scott advised claimant that he "may indeed have a legitimate reason to file a claim against his employer for noise induced hearing loss" and to transfer to a less noisy job if one was available. (Id. at 2). Finally, claimant saw Dr. Scott on August 5, 1991. Dr. Scott "again quizzed [claimant] regarding any prior significant noise exposure and could not find any in his history. At this point I recommended that he * * * file a claim against his employer for noise induced hearing loss." (Id).

Although the evidence is close, we find that Dr. Scott did not "simply and directly" inform claimant of his occupational disease on July 30, 1991 since Dr. Scott indicated that claimant's job only "may" have caused his hearing loss. It was not until August 5, 1991 that Dr. Scott "simply and directly" informed claimant that he had an occupational disease by recommending that he file a claim against the employer. Therefore, we agree with claimant that he satisfied ORS 656.807(1)(b) by filing his claim within one year of that date.

Alternatively, even if we were to find that claimant did not satisfy ORS 656.807(1), we would find that his claim was not barred because of the insurer's failure to establish that it was prejudiced by late filing. Under ORS 656.265(4)(a), failure to provide timely notice does not bar a claim unless "the insurer or self-insured employer has not been prejudiced by failure to receive the notice[.]" This provision is applicable to the filing of claims for occupational diseases. Inkley v. Forest Fiber Products Co., 288 Or 337, 347 (1980). Furthermore, it is the insurer's burden to prove prejudice. Id. at 348. We find no merit to the insurer's argument that this burden was shifted to claimant by the 1987 amendments requiring claimants to prove compensability.

Here, the insurer asserts that it was prejudiced because, if claimant had filed his claim earlier, the employer could have limited its potential liability by arranging for more hearing protection or a job change. We are not persuaded by the insurer's argument. As early as September 1988 the employer was aware that, based on employer-sponsored hearing tests, claimant's hearing was not within normal limits. (Ex. 10). Although the test results did not necessarily indicate that the work place caused claimant's hearing loss, they at least put the employer on notice of a potential claim and the possible need to limit its liability. Therefore, we conclude that, because the employer had notice of a potential claim before claimant was first examined by Dr. Scott, any failure by claimant to timely file his claim had no effect on the employer's opportunity to limit its potential liability. Therefore, even if claimant failed to timely file his claim, it would not be barred. Thus, we proceed to the merits.

Compensability

The record contains two opinions regarding the cause of claimant's hearing loss. Dr. Springate, otolaryngologist, found that, because claimant began working for the employer in 1982 but was not tested until 1988, he could not accurately state when claimant lost his hearing. (Ex. 5-3). Dr. Springate reported that the "pattern of his hearing loss is not necessarily that associated with acoustic trauma and it could be that this might be a congenital type of hearing loss since the level of noise he has been exposed to and the number of years does not seem adequate to cause this degree of hearing loss." (Id).

Dr. Scott, who is also an otolaryngologist, agreed that, without audiogram test results from 1982, it was not possible to know claimant's degree of hearing when he started working for the employer. (Ex. 8-2). However, based on claimant's reported history, Dr. Scott found that claimant's "hearing was relatively normal or without any significant degree of hearing loss at the onset of his employment in 1982. I do accept the fact that from 1982 to 1988, this is a significant degree of hearing loss and it's more than I would expect from a person, even being employed in a very noisy environment." (Id. at 2-3). Again based on claimant's history, however, Dr. Scott concluded that the major contributing cause to claimant's hearing loss was his employment. (Id. at 3, Ex. 9-1).

In response to Dr. Springate's opinion, Dr. Scott stated that congenital or hereditary hearing loss was not probable since claimant's hearing loss had stabilized over the last three years, when he was wearing ear protection. (Exs. 8-3, 9-1). In this regard, Dr. Scott opined that claimant's slightly increased hearing loss between 1988 and 1992 was not significant and is "the difference that may be seen just from one test to the next test." (Ex. 9-1).

Unless there are persuasive reasons to the contrary, we normally defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). We find no reason not to do so in this case. Dr. Scott saw claimant several times over a three-year period and provided a well-reasoned opinion based on a complete history. Therefore, based on Dr. Scott's opinion, we conclude that claimant proved that the major contributing cause of his hearing loss was his employment and, thus, he proved the compensability of his claim. See ORS 656.802(2).

Claimant finally prevailed over the insurer's denial and, therefore, is entitled to an assessed attorney fee. See 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 services at hearing and on review 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 record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 19, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the insurer.

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In the Matter of the Compensation of
**BENNIE J. MATHENA, Claimant**
WCB Case No. 92-02144
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Spangler's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a left knee condition; and (2) declined to assess penalties and related attorney fees for the employer's allegedly unreasonable denial. In the event the Board does not find the claim compensable, claimant moves to remand this case to the Referee for inclusion of a doctor's report that was not available on the date of hearing. On review, the issues are remand, aggravation, and penalties and attorney fees. We deny the motion and affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," as supplemented.

In preparation for the hearing, claimant's attorney referred him to Dr. Matteri. Claimant was examined by Dr. Matteri on March 27, 1992, rather than 1982. However, because the attorney did not secure a medical release signed by claimant, he was unable to request a copy of that examination report until April 27, 1992. The attorney further delayed requesting a narrative report from Dr. Matteri pending his review of the doctor's chart notes. Dr. Matteri "faxed" a medical report to claimant's attorney on the morning of the May 5, 1992 hearing. That report was admitted into evidence.

At hearing, claimant moved to leave the record open for receipt of a narrative report from Dr. Matteri. Finding that claimant's attorney did not exercise due diligence in securing the report prior to hearing, the Referee denied the motion.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

On review, claimant moves to remand this case to the Referee for inclusion of the narrative report from Dr. Matteri. Claimant contends that the proffered evidence is reasonably likely to affect the outcome of this case, and that it was not obtainable with the exercise of due diligence at the time of the hearing.

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 clearly be 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. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986).

Here, we agree with the Referee that the evidence claimant now seeks to admit was obtainable with the exercise of due diligence at the time of the hearing. Claimant's attorney referred him to

Dr. Matteri in preparation for the hearing. Dr. Matteri examined claimant more than five weeks prior to hearing. However, claimant's attorney did not obtain a written release from her client in order to obtain a copy of the doctor's records until one week prior to the hearing. Further, claimant's attorney elected not to seek a narrative report from Dr. Matteri (concerning the relationship between claimant's October 1991 left medical meniscus tear and his accepted 1987 left knee claim) until he could review the doctor's chart notes. Under such circumstances, we find that the evidence claimant now seeks to admit was obtainable with the exercise of due diligence.

Moreover, we do not consider the present record, without an additional report from Dr. Matteri, to be improperly, incompletely, or insufficiently developed concerning the issue of compensability. The present record establishes the possibility that claimant's 1991 left medical meniscus tear is related to his accepted 1987 workers' compensation claim. In his March 27, 1992 chart notes, Dr. Matteri opined that it is "plausible" that there is a cause and effect relationship between the two conditions, and noted that there is "no evidence" that claimant's torn medical meniscus "is not the result of" the prior work injury. However, Dr. Matteri relied on an incorrect history of ongoing knee pain and swelling. As Dr. Matteri has an incorrect history from claimant, we would not find his further opinion concerning causation to be persuasive. Accordingly, we do not find that the proffered evidence is likely to affect the outcome of the case. For these reasons, claimant's motion to remand is denied.

Aggravation, Penalties, and Attorney Fees

We affirm and adopt the Referee's order finding that claimant has not proven a compensable aggravation of his left knee condition. We further affirm and adopt the Referee's order finding the self-insured employer's denial not to be unreasonable.

ORDER

The Referee's order dated June 2, 1992 is affirmed.

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February 26, 1993 Cite as 45 Van Natta 364 (1993)

In the Matter of the Compensation of
**KATHY R. OVERLAND, Claimant**
Own Motion No. 93-0046M
OWN MOTION ORDER
EBI Companies, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for her compensable left knee injury. Claimant's aggravation rights expired on July 25, 1983. The insurer accepted responsibility for the left knee surgery, but recommended that claimant's claim not be reopened for temporary disability until April 1993.

We may authorize 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.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

We are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, Dr. Van Olst's report of January 4, 1993 states that claimant is working. Furthermore, the insurer concedes that claimant was in the work force at the time of her worsening. Therefore, we conclude that claimant was engaged in regular gainful employment and was in the work force at the time of her disability.

However, the insurer argues that claimant is not presently entitled to temporary disability benefits because her regular job is not currently available. It argues that claimant's regular employment as an instructor of a community college class is unavailable because the class was cancelled by the community college. Since the class will not be reinstated until April 1993, the insurer argues that claimant's temporary disability should not begin until then. In effect, the insurer is arguing that claimant is not entitled to temporary disability benefits until she has an actual loss of wages.

The insurer's argument fails on two grounds. First, the relevant time to determine whether claimant is in the work force is when her compensable condition worsens. Weyerhaeuser v. Kepford, supra. As discussed above, the record establishes that claimant was in the work force when her condition worsened. In addition, the insurer concedes that fact.

Second, claimant need not prove an actual loss of wages to be entitled to temporary disability benefits. Claimant need only prove that, because of the worsening, she was less able to work in that she was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452 (1991), citing Smith v. SAIF, 302 Or 396, 401 (1986).

Here, claimant has established that her compensable worsening resulted in her being less able to work to such an extent that she was temporarily incapacitated from regularly performing work at a gainful and suitable occupation. Thus, claimant is entitled to temporary disability benefits from the date of her compensable worsening.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning January 22, 1993, the date she was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

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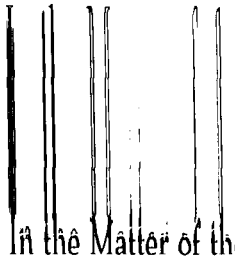
In the Matter of the Compensation of
**JUANA PIPER, Claimant**
Own Motion No. 92-0421M
OWN MOTION ORDER OF ABATEMENT
Scott McNutt, Claimant Attorney

Claimant requests reconsideration of our January 29, 1993 Own Motion Order. In that order, we determined that claimant was not in the work force at the time of her worsening. On that basis, we denied claimant's request for temporary disability benefits. With her request for reconsideration, claimant submits an affidavit stating that she was in the job market and looking for work during the



In the Matter of the Compensation of
**JANICE D. RAYMER, Claimant**
WCB Case No. 92-00359
ORDER ON REVIEW
Max Rae, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Moller and Hooton.

The SAIF Corporation requests review of Referee Brazeau's order which: (1) set aside its denial of claimant's neck injury claim; and (2) assessed a penalty-related attorney fee for its allegedly unreasonable denial. On review, the issues are compensability, penalty and related attorney fee. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. On page 1 of the Opinion and Order, second paragraph under "Findings of Fact", the alleged date of injury should be November 12, 1991, not August 12, 1991.

## CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's neck injury compensable, based on his finding that the work incident was a material contributing cause of her need for treatment. Finding that claimant had a preexisting neck condition, the Referee applied ORS 656.005(7)(a)(B) and the two-step analysis we set forth in Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991). The Referee concluded that claimant had established a compensable injury which was a material contributing cause of her subsequent need for medical treatment. We agree with the Referee's conclusion, but offer the following reasoning.

Subsequent to the Referee's order, the Court of Appeals found our two-step analysis to be incorrect. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Instead, the court stated that, under ORS 656.005(7)(a)(B), "when a work-related injury combines with a preexisting condition to cause . . . a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the . . . need for treatment." Tektronix, Inc. v. Nazari, supra, 117 Or App at 412-13 (emphasis in original).

Here, we find no evidence that claimant's preexisting condition combined with the work-related injury to cause the need for claimant's treatment. See Gary Stevens, 44 Van Natta 1178 (1992). No medical evidence establishes such a combination. Moreover, claimant credibly testified that although she periodically sought chiropractic treatment for episodic, relatively mild pain since a motor vehicle accident approximately 15 years ago, she had severe pain in her neck, mid-back and upper shoulders when she sought treatment from Dr. Whitmire, her treating chiropractor, after the November 12, 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 $750, 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. We have also considered that 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 April 3, 1992 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

**Board Member Hooton dissenting.**

I agree with the majority in its resolution of the issue of compensability. However, I do not agree with the resolution provided by the majority to the question whether the Referee abused his discretion in admitting Exhibit A, documents related to claimant's treatment by chiropractor Dr. Whitmire on September 25, 1991. While the admission of this evidence did not, ultimately, prejudice this claimant, who demonstrated compensability despite the misconduct of SAIF Corporation, the admission violated the principles and rules of full disclosure adopted by the Board and applicable to all hearing procedures. By admitting the documents in question the Referee deprives all claimants of the assurance that disclosure by the insurer is full and fair, and perpetuates a practice that is objectionable and in violation of the rules of practice and procedure.

OAR 438-07-015(2) requires the full disclosure of all documents related to the claim. It also provides that failure to disclose is a basis for exclusion upon motion of any party.

OAR 438-07-015(6) provides that the Referee may admit a document not previously disclosed as required by OAR 438-07-015(2), but requires a finding regarding prejudice and good cause. The document is admissible only if there is no prejudice or the prejudice that results is outweighed by good cause for the failure to disclose.

Finally OAR 438-07-017 states that impeachment evidence need not be disclosed. However, that rule identifies impeachment evidence as evidence which is "reasonably believed relevant and material only for purposes of impeachment of a witness."

These are the rules of practice and procedure that have a bearing on the admissibility of Exhibit A in the present claim. I will consider the application of OAR 438-07-017 first.

Exhibit A does not fit the definition of impeachment evidence as established by Board rule. The rule requires that you examine the nature of the evidence, not the purpose for which it is offered. It is not enough that an insurer intends to use evidence as impeachment evidence to avoid the requirements of disclosure. The rule requires that the evidence itself be such that the only reasonable purpose for admission is impeachment. If the evidence contains material that is substantive in nature and which is, therefore, relevant and material for a purpose other than impeachment, it is not impeachment evidence and disclosure is required.

In this case the evidence establishes a preexisting cervical and thoracic strain. That fact is material and relevant to any claim in which compensability may involve a heightened burden of proof under ORS 656.005(7)(a)(B). The evidence may not be sufficient to establish the requisite combination, [illegible] its relevancy to the existence of the condition, and, consequently, the

impeachment of a witness. Because SAIF is the party seeking the heightened burden of proof it has to be aware of the substantive character of the evidence. Disclosure was required! OAR 438-07-017.

Under OAR 438-07-015(2) Exhibit A had to be disclosed within 15 days of the initial request for documents or within 7 days of receipt if not in possession at the time of first disclosure. The remedy available to the adverse party for failure to disclose is exclusion, or the imposition of a penalty pursuant to ORS 656.262. In this case, the claimant seeks only the exclusion of the document.

Under OAR 438-07-015(6) it is apparent that the desired result is exclusion. That provision permits the Referee to admit the evidence, only if the Referee first finds that the failure to disclose caused no material prejudice, or, in the alternative, that the insurer had good cause for the failure to disclose. Given that the Board has not yet considered what evidence is required to establish the combination of a preexisting condition and a compensable injury under ORS 656.005(7)(a)(B), the failure to disclose the evidence establishing the existence of a preexisting injury is necessarily prejudicial to some degree. Certainly, it limits the ability of claimant's attorney to prepare his case on the issue of compensability. No argument is provided by SAIF to establish good cause for the failure to disclose, and none is readily apparent in the record. Instead, SAIF relies upon an assertion that the document is impeachment and therefore not subject to the rule. SAIF is wrong.

While ORS 656.283(7) provides that the rules of evidence and procedure are not applicable to a hearing before the Board, or its Hearings Division, and grants discretion to the Referee to conduct a hearing in any manner that will achieve substantial justice, that same statute subjects that discretion to rules of practice and procedure adopted by the Board. Where the Board has acted, the Referee must conform the hearing to the rules. When a rule requires specific findings prior to the admission of any document those findings must be made, or the document excluded. Here, the Referee failed to make the necessary findings but admitted the document without regard for the requirements of the rule. That act is an abuse of discretion, simply because it violates the rules of procedure adopted to govern that conduct. The Board's affirmation of the Referee's decision without, itself, providing the necessary findings is equally inappropriate. When we have constrained our own conduct by the adoption of rules, we are no longer free to act as we choose, but must abide by the rules we have created.

The mere fact that the Referee ultimately concluded that the claimant was credible does not mean that the evidentiary ruling was correct. The "no harm, no foul" approach to evidentiary questions of this kind rewards SAIF for its failure to disclose and continues a practice which is in violation of our rules and the best interest of all the parties. The purpose of the Workers' Compensation Law that is addressed by that rule is the need to apply the law in a manner that promotes a fair and just administrative system that reduces litigation to the greatest extent practicable. See ORS 656.012(2). Full disclosure increases the probability of settlement, and in the absence of settlement, a fair opportunity to present evidence necessary to establish, and defend, the claim. Trial by ambush discourages settlements by hiding knowledge which permits the parties to accurately evaluate the claim. Further, by its very nature, it rewards deception and deprives the parties of a full and fair opportunity to defend their respective interests. We need to diligently police the efforts of the parties to provide full disclosure of all documentary evidence relevant and material to the claim.

In the Matter of the Compensation of
**RUBEN G. ROTHE, Claimant**
WCB Case No. 91-10090
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Thye's order that upheld the SAIF Corporation's denial of claimant's head injury claim. On review, the issue is the compensability of claimant's head injury. We affirm.

Unless otherwise authorized by the Board, supplemental briefs are not considered on review. OAR 438-11-020(2); Betty L. Juneau, 38 Van Natta 553 (1986). Nevertheless, after receiving the parties' briefs on review, the Board asked for and received supplemental briefing on the issue of the remaining viability of Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), in light of the enactment of ORS 656.266.

Furthermore, the Board will not ordinarily entertain oral argument. OAR 438-11-015(2). However, because this case presented an issue of first impression which could have a substantial impact on the workers' compensation system, the Board determined that oral arguments were an appropriate method of assisting the members in conducting their review. Consequently, on January 13, 1993, recorded oral arguments were heard by the Board en banc. After considering those arguments and the parties' appellate briefs, the Board issues the following decision.

## FINDINGS OF FACT

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

Drs. Brady and Kimberly reviewed claimant's medical records, as well as photos of the worksite.

## CONCLUSIONS OF LAW

The Referee concluded that claimant had failed to prove the compensability of his injury claim. In doing so, the Referee found insufficient evidence to explain the mechanism of the fall that resulted in claimant's injury. The Referee analyzed this case as involving an "unexplained versus idiopathic" injury, and concluded that claimant had failed to rule out all "idiopathic" causes of his injury. The Referee further concluded that claimant's worksite did not provide an increased risk such that any injury occurring there should be compensable. The Referee, therefore, approved SAIF Corporation's denial.

On review, claimant argues that his fall was, in fact, "unexplained" and, therefore, compensable. He asserts that ORS 656.266 did not overrule Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), but was merely intended to clarify the way in which certain claims might be proved. SAIF Corporation, on the other hand, asserts that claimant's head injury arose from "idiopathic" causes and, even if it did not, claimant has failed to prove his claim under ORS 656.266.

After reviewing the record and considering the arguments of the parties, we conclude that claimant's claim is not compensable. First, assuming that Russ, supra, remains viable in light of ORS 656.266, we conclude that claimant's injury was "idiopathic," rather than "unexplained."

A work injury is compensable if it "arises out of and in the course of employment." ORS 656.005(7)(a). In Rogers v. SAIF, 289 Or 633 (1980), the Court adopted a unitary work-connection approach to compensability, stating: "If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied." Id. at 643.

This unitary work-connection analysis, in turn, adopted the "quantum" theory of work-connection, as articulated in 1 Larson, Workmen's Compensation Law, 29.10 at 5-355 (1985). The quantum approach permits a proportional application of the "course of employment" and "arising out of" factors in establishing the extent to which the worker's injury is related to his employment.

As noted in Russ, supra, under the unitary work-connection approach, a worker cannot prove the compensability of his claim merely by establishing that his/her injury occurred at work, i.e., in the "course of employment." The worker must also establish that the injury was in some way linked to the work activity in which he/she was engaged.

One way to establish the requisite causal link is to prove that the worker's injury was "unexplained." In Russ, supra, the Court held that where a fall on the job is unexplained, the law assumes that it was related to work, provided that the worker proves that the cause of the fall was not "idiopathic," i.e., "peculiar to the individual." Id. at 27. To do so, the worker must establish that the injury was more likely work-related than idiopathic. Id. at 30.

The claimant in Russ unaccountably fell while walking on the job. By way of the medical evidence, he proved that his injury did not result from any cause "peculiar" to himself. Under these circumstances, the Court held that the worker's fall was truly unexplained and, therefore, compensable. In Mackay v. SAIF, 60 Or App 536 (1982), on the other hand, the worker proved only that it was equally possible that his injury was work-connected, as opposed to idiopathic. Under these circumstances, the court denied compensation. Id. at 539.

In the present case, we conclude that claimant has failed to rule out idiopathic causes, of which there are potentially two. The first is an alcohol withdrawal seizure. Dr. Brentlinger, who examined claimant at Oregon Health Sciences University on the day of his fall, noted that claimant "may be experiencing ETOH [alcohol] withdrawal." Dr. Trunkey, claimant's treating physician, listed "alcohol withdrawal seizure" as claimant's final diagnosis. Trunkey later noted that the timing of claimant's cessation of alcohol consumption was consistent with his having experienced a seizure at work.

Dr. Brady, whose specialty is unknown, reviewed claimant's medical history, along with photos of claimant's work area. Brady opined that claimant's head injury occurred "directly" as a result of the work he was performing on June 6, 1991. In reaching this conclusion, Brady stated that an alcoholic seizure "by itself" was not a reasonable explanation for claimant's injury, and had claimant been "sitting in a couch or resting in bed" at the time of his accident, "the injury would not have occurred when and where it did."

Dr. Kimberly also reviewed claimant's medical records and photos of the work area. As did Brady, Kimberly opined that claimant's injury likely occurred as a result of his work activity - specifically, tripping over a bumper jack. Kimberly further noted that an alcohol seizure would have been unlikely if claimant continued to consume alcohol up to the day before his fall. Kimberly did admit, however, that the "greatest likelihood of alcoholic seizure occurs 48 to 72 hours after the last drink . . ." Finally, Kimberly noted that "there is simply not enough factual medical evidence to blame this type of injury solely on acute alcohol withdrawal."

We conclude that the opinion of claimant's treating physician, Dr. Trunkey, is the most persuasive. Because he is the treating physician, his opinion is entitled to greater weight, absent persuasive reasons not to afford it such. Weiland v. SAIF, 64 Or App 810 (1983). In the present case, there are no persuasive reasons not to defer to Trunkey's opinion. He had a complete history of the circumstances surrounding claimant's fall, and he correctly assumed that there was no other established cause of it.

The opinions of Drs. Brady and Kimberly, on the other hand, effectively assume that claimant's injury resulted from a trip and fall over a bumper jack at work. The only evidence supporting that assumption, however, is that there was a jack in the general vicinity where claimant was working. No one, including claimant, could testify that he did, in fact, trip over the jack. Neither was there other evidence linking the jack to the fall. The physicians' assumptions to the contrary were, therefore, necessarily based on speculation, thereby reducing the persuasiveness of their opinions.

Further, Drs. Brady and Kimberly appear to suggest that if claimant did experience an alcohol seizure at work, it could not have been the sole cause of his head injury. Brady, for example, suggests that had claimant had a seizure in bed or while sitting on a couch, his injury may not have occurred as it did. That, however, is beside the point; if claimant did have the seizure and the seizure itself was not caused by working conditions, it was, by definition, "idiopathic," and any injury occurring therefrom is not compensable. We cannot conclude from the reports of Drs. Brady and Kimberly that claimant has ruled out the occurrence of an alcoholic seizure on June 6, 1991.

There is a second potential idiopathic cause of claimant's injury, i.e., a low level of sodium in claimant's blood at the time of his injury. The low sodium level was noted while claimant was hospitalized and, according to Dr. Kimberly, claimant was as likely to have experienced a seizure from this condition as from an alcohol withdrawal seizure. From this evidence, we conclude that claimant has failed to rule out this idiopathic factor as a potential cause of his fall at work.

Claimant argues, however, that even if he has failed to rule out all idiopathic causes, his claim is compensable because his injury was caused by the "increased risk" presented by his working environment.

The "increased danger rule" was adopted by the court in Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991). The court held that where an injury would not have occurred but for the work environment having placed the worker at increased risk of being injured, the resulting injury is considered to have both arisen out of and occurred in the course of employment. See also I Larson, supra, Sec 12.00 at 3-308 (1985).

In the present case, the parties agree that claimant's injury occurred at the worksite. SAIF argues, however, that the injury was not caused by anything inherent in the either the work or the workplace itself. We agree.

In Emery A. Reber, 43 Van Natta 2373 (1991), we found a worker's injury resulting from an idiopathic fall to be compensable, based on our conclusion that his work environment presented an increased risk of injury. The worker fell while working on a roof, which was two stories above the ground. We concluded that because the worker was required to work several feet off the ground, the working environment presented an increased risk that he would be injured.

In the present case, on the other hand, claimant's work environment presented no inherent risks different from those encountered by any person walking or standing on a concrete floor. While it may be argued that an increased risk of injury results from working on concrete, as opposed to a carpeted floor, for example, we conclude that that "increase" is not sufficient to invoke the principles set forth in Marshall v. Bob Kimmel Trucking, supra.

Finally, SAIF argues that even if claimant succeeded in establishing that his injury resulted from "unexplained" as opposed to "idiopathic" causes, his claim is not compensable by virtue of ORS 656.266. Again, we agree.

ORS 656.266 was enacted in 1987, after the Court's decision in Russ, supra. See Or Laws 1987, Ch. 713, Sect. 2. It provides, among other things, that the burden of proving that an injury is compensable is upon the worker. It further provides: "A worker cannot carry the burden of proving that an injury . . . is compensable merely by disproving other possible explanations of how the injury . . . occurred."

The legislative history preceding the enactment of ORS 656.266 reflects that it was the intent of the Legislature to overturn the court's decision in Bradshaw v. SAIF, 69 Or App 587 (1984). In that case, the claimant suffered headaches that she asserted were related to her compensable foot injury. Although the cause of the headaches could not be determined in the record, the court held them to be compensable on the principle that claimant had established that there were no other possible causes thereof. Id. at 589.

On April 23, 1987, Representative Shiprack testified that the proposed legislation that would later become ORS 656.266 was designed to require the Board and courts to decide cases on "clearly proven facts instead of deductive reasoning . . ." In so testifying, Shiprack referred specifically to the court's reasoning in Bradshaw, supra. See Transcript of Proceedings, Senate Committee on Labor, April 23, 1987, at 3. The substance of Shiprack's testimony was echoed by other witnesses before the legislative body. See Minutes, Interim House Task Force on Occupational Disease, October 8, 1986, pp 4-5, 14 and Exhibit G at 2; Transcript of Proceedings, House Committee on Labor, March 25, 1987 at 55 (App. C).

In reaching its conclusion in Russ, the Court reasoned:

"Where idiopathic causes for an unexplained fall have been eliminated, the inference arises that the fall was traceable to some ordinary risk, albeit unidentified, to which the employment premises exposed the employe." Id. at 32.

Therefore, the Court relied on an inferential conclusion based on an elimination of other possible explanations for the claimant's fall. In light of the unambiguous statutory provision in ORS 656.266 that the compensability of an injury cannot be established "merely by disproving other possible explanations," we conclude that the Russ rationale has been effectively overruled.[1]

Accordingly, in the present case, we conclude that even if claimant had ruled out all idiopathic or other non-work causes of his injury, ORS 656.266 would require him to do more, that is, to affirmatively prove that his injury was, in fact, related to his working environment. Had he, for example, proved by direct or circumstantial evidence that he did, in fact, trip over a bumper jack and hit his head on the floor, he would have satisfied ORS 656.266. However, because claimant, at best, established that his fall was "unexplained," it cannot be said that he affirmatively proved the requisite causal link between his work and his injury. Under ORS 656.266, therefore, his claim is not compensable.

ORDER

The Referee's order dated December 24, 1991 is affirmed.

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[1] Dissenting Member Hooton asserts that, because Damis v. Cotter & Co., 89 Or App 219 (1988), which applies the Russ rationale, was decided after the enactment of ORS 656.266, we are required to follow Damis and, therefore, apply the Russ analysis in the present case. However, the claimant in Damis was injured prior to the enactment of ORS 656.266. Therefore, the court correctly applied the law in effect at the time claimant was injured, i.e., the law prior to the enactment of ORS 656.266. See ORS 656.202.

**Board Member Gunn dissenting.**

The majority concludes that claimant's claim is not compensable because he failed to rule out all idiopathic factors that could have contributed to his fall. The majority further concludes that ORS 656.266 effectively overruled the Supreme Court's decision in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983). Because I disagree with the majority as to both its factual conclusion and its interpretation of the law, I am compelled to dissent. I write separately because I would only detract from Member Hooton's respected dissent and considerations of this case.

Initially, I disagree with the majority's conclusion that claimant has not ruled out all idiopathic factors. I would rely on the opinions of Drs. Brady and Kimberly to conclude that claimant has ruled out an alcoholic seizure and a low sodium level as possible causes of his fall and resulting injury. Therefore, I would consider this case to represent a truly unexplained fall at the workplace.

Although the majority decides this case on the factual basis, i.e. claimant has not ruled out all idiopathic causes, it goes on to find that either by accident or on purpose, the legislature effectively repealed the Court's holding in Russ, supra with the addition of ORS 656.266 in 1987.. The result is that claimant still loses even if this a truly unexplained fall. The majority to reaches this conclusion in spite of the confusing legislative history which indicates that on one hand, the legislature did not intend to overrule any caselaw, but on the other hand, specifically referenced problems created by Bradshaw v. SAIF, 69 Or App 587 (1984)(the infamous Sherlock Holmes case). Oddly enough, the Russ decision is not mentioned.

The facts in the Russ and Bradshaw cases are different. However, the language of ORS 656.266 could be read to apply to both cases. In both cases the claimant has to disprove certain elements to establish compensability, nonetheless there are distinguishable differences. In Bradshaw, the claimant eliminated all medical causes for claimant's illness and, based on her treating doctor's opinion and symptoms contemporaneous with the injury, the court found the condition must be compensable. By so concluding, the court impliedly found that the risk of injury should be with the employer. In Russ, the claimant disproved certain factors only to establish that the risk elements of causation were neutral. Therefore, because the claimant had an injurious event at work and the disability is known, the Court found the injury compensable.

The only question presented by these cases is who bears the risk, the worker or the employer. I submit that questions concerning whether the worker or the employer bears the risk are two different evidentiary matters. To conclude, as the majority does, that ORS 656.266 was also intended to have claimant bear the the risk and responsibility for an injury where the risk involved is neutral goes both beyond the actual words of the statute and the legislative reference to the Bradshaw case. Frankly, it does not take Sherlock Holmes to figure it out the legislative intent was to only repeal Bradshaw and its progeny.

Consequently, I conclude that ORS 656.266 was not enacted to overrule Russ, supra and make claimant bear the cost of an injury that occurs in a neutral risk situation. Rather, ORS 656.266 was enacted to overule the court's decision in Bradshaw and place the risk of injury with claimant in situations where a claimant has only ruled out idiopathic factors.

Regardless of whether or not ORS 656.266 overruled Bradshaw, I believe that when ORS 656.005(7)(a)(A) and (B) were enacted in 1990, their enactment affected the way we apply evidentiary burdens under ORS 656.266. ORS 656.005(7)(a) requires that a compensable injury be established by "objective findings." This provision, if applicable to Bradshaw, might establish compensability in spite of ORS 656.266. In Bradshaw, the treating physician opined that that claimant's subjective complaints, which were contemporaneous with the injurious event, lead to the conclusion that her condition was work-related. Such evidence would provide "objective findings " within the meaning of ORS 656.005(19). See Suzanne Robertson, 43 Van Natta 1505 (1991).

It must be remembered that two elements of the Worker Compensation Act remained unchanged through both 1987 and SB 1197 enacted in 1990. One, claimants do not have to file claims (just report injuries) and the processing of those claims is the legal responsibility of the insurers and employers. Claimant's legal obligations to process information arise when the claim is denied. This at least implies that the system was not changed to require proof from a claimant at the time his or her head hits the floor or as in this case, the concrete. Legal, rational interpretation can only conclude claimant's burden under pursuant to ORS 656.266 begins with a denial (hopefully specific) of the claim. Additionally, under ORS 656.262(6) a carrier's were allowed additional time to investigate a claim as well as a two year period in which to deny a previously accepted claim.

The legislative patchwork created in 1987 with 656.266 and in 1990 with changes in the definition of compensable injuries, requires acknowledgment of other changes in how a fact-finder views evidentiary burdens. If a workers' burden of proof does not begin prior to the denial and carriers have sole responsibility to process claims, then the application of the limitations set forth in 656.005(7)(a)(A) and (B) presents some difficulties.

The Court of Appeals recently rejected our two-part test for injuries and pre-existing limitations in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). This rather inelegant two-step process was devised by this Board to reconcile the legislative history indicating that the "material contributing cause" standard was still applicable to accidental injuries with the other limitations set forth in ORS 656.005(7)(a)(B) which imposed a higher standard for those workers with preexisting conditions. Under Nazari, supra the "material contributing cause" standard no longer applies to all accidental injuries. Particularly those accidental injuries sustained by the majority of our aging workforce which is composed of the baby boomers most of whom are now at or over age forty.

This is consistent with medical research which indicates that the majority of people have degenerative pre-existing conditions. For example, almost all people over the age of forty have some degenerative disc disease. When presented with a claim for a lifting injury, a carrier could legitimately deny compensability if it possessed our age. The worker now must prove (disprove) that his or her degenerative disc disease, in combination with the injurious event, is not the major contributing cause of the resultant disability or need for treatment. SB 1197 will not only have removed chiropractors from the ranks of attending physicians, but would also effectively prevent the majority of the work force from establishing a compensable injury. A neat trick but one that I am hard pressed to adopt nor do I perceive from the legislative history to be intended.

I believe the only way to reconcile the burden of proof with the statutory limitations on compensability, is to place responsibility upon the insurers who are processing the claim to determine if

a pre-existing condition exists and if it has combined with the injury. Once that is brought forth as the basis for a denial, the worker can then be required prove the injury is the major cause of disability and need for treatment. The only other alternative is that injured workers would have to have certificates of health at the time of injury listing real or potential pre-existing factors.

Turning to the instant case, the issue here is what risk factors were associated with the workplace. There is no question the employee was at work and potential hazards at the workplace could have contributed to his fall. The claimant fell at the workplace and bled on the floor. ORS 656.266 is satisfied in that the evidence is more true than not that an accidental injury occurred arising from and in the course of work. The injury caused disability which was supported by objective medical findings. To adopt the majority's conclusion abandons the neutral risk doctrine and places a burden not supported by the words or intent of ORS 656.266 and the legislative history. Therefore I must respectfully dissent.

**Board member Hooton dissenting.**

I disagree with the majority resolution of this claim both as to its factual conclusions and its discussion of the continued viability of Phil A. Livesley Co. v. Russ, 296 Or 25 (1983). While I agree with Board member Gunn that the preponderance of the evidence establishes that claimant has ruled out all relevant idiopathic factors, the medical record is divided. While the better view may indicate that claimant was successful in ruling out idiopathic factors, the standard of review beyond this Board is not preponderance of the evidence, but substantial evidence in the record as a whole. While I regret that the standard of review permits this body, occasionally, to ignore the requirement that it decide facts consistent with the greater weight of the evidence, a discussion of evidence will not be of assistance to any party, since there is substantial evidence in the record which permits the finding the majority has made, albeit erroneously. This case, having been decided on a factual rather than a legal issue, is virtually non-appealable under the standard of review currently applicable.

That fact alone gives rise to my further objections to the majority decision in this matter. In 1983 the Supreme Court, after serious deliberation stated a rule for application in "unexplained fall" cases. The court concluded that it was permissable for parties in workers' compensation cases to prove elements of their claims or defenses indirectly, by circumstantial evidence. In the "unexplained fall" cases this means that claimant can prove the necessary work relationship by disproving idiopathic explanations for the fall. The logic involved is simple and indisputable. Where claimant is injured on the job site, the injury is compensable if there is a connection between the injury and work activities, and is not compensable if the injury was caused by factors peculiar to the individual. By proving that there are no factors peculiar to the individual, claimant proves indirectly that, whatever the cause of the injury, it must have arisen out of the employment exposure.

In 1987 the legislature adopted ORS 656.266 which codifies the long standing principle that claimant bears the burden of proving compensability, and goes on to state that "[t]he worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred". The majority concludes that this additional language effectively overrules the principles of Phil A. Livesley v. Russ, supra. Consequently, the majority concludes that even if claimant has ruled out all idiopathic factors, he still has not established a compensable claim.

The first problem with this argument is that it is only dicta. Because it was never necessary for the majority to reach this conditional conclusion, the statement of law is not necessary to the decision, and has no stare decisis effect upon any future litigation. The pronouncement is by way of a declaratory judgment involving facts other than the facts as found in the present dispute. We have more than enough to do without presuming to overrule prior Supreme Court precedent on a whim.

Even if there are indications that would justify reaching this issue, other than those which we have created ourselves, the majority's conclusion that ORS 656.266 effectively overruled Phil A. Livesley v. Russ, supra is quite simply wrong.

There are many components of compensability litigation to which the language in ORS 656.266 might be made to apply. The statute does not indicate an intention to restrict or remove the general use

of circumstantial evidence in establishing compensability. Neither does it indicate whether the principle laid down is to apply in every facet of compensability litigation, or is limited to a particular subset of workers' compensation claims. Consequently, the statute is, by its very nature, ambiguous.

The legislative history cited by SAIF Corporation in support of its contention that Russ has been overruled includes the following clear and concise statement by Representative Shiprack.

> "Section 2 of the bill is not intended to overturn any case." Transcript of Proceedings, Senate Committe on Labor, April 23, 1987 at 3.

While the legislative history goes on to note a concern for the use of deductive reasoning in workers' compensation cases, no where does the legislature, or its committees, take issue with the clear and concise statement of intent appearing above. Indeed, if the legislature intended to prevent the use of deductive reasoning in workers' compensation cases, as the legislative history cited by SAIF Corporation suggests, the language adopted does not accomplish that result. Circumstantial evidence in all its forms relies upon the use of deductive reasoning to support "reasonable inferences" in favor of both parties. The statute does not prohibit reasonable inferences, and is only applicable to claimants.

Indeed, the case in question in the legislative history is not Russ, but Bradshaw v. SAIF, 69 Or App 587 (1984). In that case evidence affirmatively established an injury in the course and scope of employment. Treatment of the injury required hospitalization, and the effects of the injury worsened claimant's preexisting diabetes and caused a high fever. Claimant also experienced a severe headache, the cause of which was unknown. However, claimant's headache was geographically remote from the injury to claimant's foot. The treating physician attempted to discover the cause of the headache without success, and eventually concluded that since every physiological explanation unrelated to the injury had proven negative, the headache must be a direct consequence of the injury. The Bradshaw case is an exception to the principle that it is not sufficient to show chronological sequence in order to prove causation, because the timing was very close, and because every other explanation had been ruled out.

It is easy to see how the legislature could have concluded that it was not overruling any case. The statutory language indicates that it is not sufficient merely to disprove other possible explanations. In both Russ and Bradshaw there is evidence in addition to the elimination of idiopathic factors which contribute to the decision. In Russ it is claimant's actual physical presence in the workplace environment. In Bradshaw it is the chronological continuity of the injury and the disputed condition.

Finally, I note that this Board is required to apply the case law developed at the Court of Appeals and the Supreme Court, and is without authority to overule or ignore that case law on its own motion. ORS 656.266 was adopted by the legislature in 1987 and has not been subsequently revised. Both Russ and Bradshaw preexisted the statute. However, in Damis v. Cotter & Co., 89 Or App 219 (1988) the Court of Appeals considered, adopted and applied the reasoning outlined in Phil A. Livesley v. Russ, supra. It is not possible for a legislative act in 1987 to overrule a case decision in 1988.[1] We are, therefore, required to apply the principle of Russ as adopted in Damis until such time as the court overrules its prior judgments, or the legislature again acts. Until such time we are required to presume that ORS 656.266 and Damis are not in conflict. The most that we can do is to advise the court, in an appropriate case, of its "potential" error. See Spencer House Moving Company, 44 Van Natta 2522 (1992).

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[1] The majority asserts that they need not consider the courts action in Damis v. Cotter & Co., supra, because ORS 656.202 prevents application of ORS 656.266 to dates of injury prior to January 1, 1988, the effective date of the statute. A Review of 1987 Oregon Laws, Chapter 713 indicates that the Act was not excepted from the provisions of ORS 656.202. The majority's point is, therefore, well taken, even though it produces absolute nonsense. What the majority can only be read to assert is that for claimant's with a date of injury prior to January 1, 1988, the burden of proof is not necessarily borne by the claimant, and that both Russ and Bradshaw, and the grossly objectionable Sherlock Holmes reasoning process, continue to apply. This creates a bifurcated system in which the referee must ascertain the date of injury prior to deciding who bears the burden of proof, and what kinds of proof are sufficient to carry that burden. Such a system is unmanageable, and must, inevitably, compound litigation by raising evidentiary considerations and blatant technicallity above the need to assure that the hearing is conducted in a manner that promotes "substantial justice".

1987 Oregon Laws, Chapter 713 begins with a unique pronouncement, not often utilized by the legislature, which establishes the purpose of the Act. It states, in its entirety as follows:

> "Whereas it is the desire of the Legislative Assembly to provide future guidance to the appellate courts of this State with respect to the interpretation of certain provisions of the Workers' Compensation Law included in this Act; now, therefore, Be it Enacted by the People of the State of Oregon. . . " (Emphasis added).

This statement, even in the absence of the legislative history commented on at length in the majority and dissenting opinions, indicates that the specific provisions of 1987 Oregon Laws, Chapter 713, where intended only as a statement of legislative intent, or history, to applied by the court to subsequent litigation. It indicates that the legislature did not believe that it was changing the law so as to produce the dichotomy the majority suggests, rendering an exception to ORS 656.202 meaningless. This is consistent with the legislative history that states in no uncertain terms that the legislature was simply codifying current law, and was not overruling or changing any decision of the court.

Finally, I would note that the court has developed a consistent practice of commenting upon legislation which would affect application of the legal principles involved in a case, but which are not applicable in the case before them for whatever reason. See, for example, SAIF v. Abbott, 103 Or App 49, 53 (1990). Because I do not believe that the court was ignorant of the enactment of ORS 656.266 when it decided Damis, I find its silence significant. However, I would assert that the court, with knowledge of the act, was aware that the legislature had intended no changes and acted accordingly.

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In the Matter of the Compensation of
**NANCY A. SEITZ, Claimant**
WCB Case No. 91-07711
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Barber's order that: (1) upheld the insurer's denial of claimant's low back condition as not arising out of and in the course of her employment; and (2) declined to assess penalties and related attorney fees for the insurer's allegedly unreasonable denial. The insurer has filed a motion to strike claimant's reply brief as untimely. On review, the issues are motion to strike, compensability, penalties and attorney fees. We deny the motion to strike, affirm in part, and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not his "Ultimate Findings of Fact." In addition, we supplement with the following.

On the weekend prior to April 27, 1991, claimant was weeding her garden when she experienced the onset of low back and bilateral leg pain. The pain was of a "muscular" character. The pain in the legs ultimately disappeared completely; however, the low back pain remained. The gardening activity was light and did not require extensive exertion or heavy lifting.

During the weekend of April 27 and 28, claimant was moving heavy patients at work when she developed more low back pain and a deeper sensation-type pain into the back of the right thigh and down the right leg. This was a new type of pain not experienced while gardening.

Claimant's right leg symptoms worsened on or about May 1, 1991, and ultimately, a herniated disc at L5-S1 was diagnosed.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

The insurer has moved to strike claimant's reply brief on the basis that it was not filed within 14 days of the mailing of its respondent's brief. The insurer relies on an August 6, 1992 postmark on the envelope sent to it containing its copy of the reply brief. We deny the motion.

Claimant's reply brief was due on August 5, 1992. OAR 438-05-046(1)(c) provides that briefs filed with the Board are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." Here, the certificate of service attached to the reply brief sent to the Board indicates that it was deposited in the mail "on the 5th day of August, 1992." Accordingly, under the applicable administrative rule, claimant's reply brief was timely filed. Ben Santos, 44 Van Natta 2228 (1992); Duane R. Paxton, 44 Van Natta 375 (1992).

### Compensability

Finding that Dr. Waldram's opinion on causation was based on an inaccurate and incomplete history, the Referee disregarded the attending physician's opinion. Consequently, the Referee concluded that claimant had failed to establish the compensability of her low back condition.

In order to establish the compensability of her low back condition, claimant has the burden of proving, by medical evidence supported by objective findings, that her work activities were a material contributing cause of her disability or need for treatment. Mark N. Wiedle, 43 Van Natta 855 (1991). We find that claimant has carried her burden of proof.

On review, claimant argues that Dr. Waldram was aware of the pain she experienced after gardening, and specifically ruled out that activity as the cause of her disc herniation. Thus, she contends, the Referee incorrectly discounted the opinion of her treating physician.

Dr. Waldram is the only physician who has offered a medical opinion concerning causation. The Board generally defers to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). However, where the opinion of any physician is based on an incomplete and inaccurate history, we do not find it persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

On the weekend prior to April 27, 1991, claimant experienced the onset of "muscular" low back and bilateral leg pain while gardening at home. Although the pain in her legs ultimately disappeared completely, the low back pain remained. During the weekend of April 27 and 28, claimant performed heavier nursing work than usual. While moving heavy patients, she developed more low back pain and a new, different type of pain in the right thigh which radiated down the right leg.

Dr. Waldram examined claimant, took her history, obtained an MRI scan, and diagnosed a herniated disc. Unlike the Referee, we do not find that Dr. Waldram "downplayed" the gardening episode or failed to record "that claimant suffered any symptoms as a result of gardening." To the contrary, we find that Waldram was aware of claimant's gardening activity. He noted that claimant had weeded for two to three hours the previous weekend, and that that activity had not required extensive exertion or heavy lifting. He also recorded that the gardening activity caused claimant some low back discomfort. After discussing all of claimant's activities, Dr. Waldram opined that, compared to only two to three hours of weeding, it was claimant's repetitive heavy work that weakened her L5-S1 disc, thereby resulting in its ultimate herniation.

We find that Dr. Waldram based his opinion on a complete and accurate history. Consequently, claimant has established the compensability of her low back condition by a preponderance of the evidence.

### Penalties and Penalty-Related Attorney Fee

We affirm and adopt the Referee's reasoning and conclusion that the insurer's denial was not unreasonable when issued. Thus, no penalty or related attorney fee is warranted.

Attorney Fees at Hearing and on Board Review

Claimant's attorney is entitled to a reasonable assessed fee for his services at hearing and on review concerning the compensability issue. 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 is $3,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 6, 1992 is affirmed in part and reversed in part. That portion of the order that upheld the insurer's denial is reversed. The denial is set aside, and the claim is remanded to the insurer for processing according to law. 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 fee of $3,000, payable by the insurer.

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In the Matter of the Compensation of
**BERTHA VEGA, Claimant**
WCB Case No. 92-02211
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of Referee Michael V. Johnson's order which: (1) found that claimant had good cause for her untimely filed request for hearing; and (2) set aside the insurer's denial of claimant's low back injury claim. On review, the issues are timeliness and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On July 25, 1991, claimant filed a claim for a low back injury allegedly sustained on July 13, 1991. (Ex. 3). The insurer denied the claim by a letter dated October 16, 1991. (Ex. 5). Claimant testified that she received the denial letter some time after October 16, 1991 and before December 1991. (Tr. 23, 25-26). Immediately upon receiving the letter, claimant asked her 11-year-old daughter to read it to her, as claimant does not read English herself. (Tr. 14-16). The daughter interpreted the letter as saying that claimant's case was closed. (Tr. 15-16). On February 6, 1992, claimant consulted an attorney. (Tr. 17). Claimant's attorney filed a request for hearing on February 11, 1992.

The Referee found that claimant had timely filed her request for hearing because she had shown good cause for failing to file by the 60th day after notification of the denial. ORS 656.319(1)(b). The Referee reasoned that since the insurer knew in this case that claimant had deficiencies in understanding English, fairness dictated that the insurer provide a Spanish language version of the denial. Therefore, the Referee concluded that claimant had shown good cause for failing to promptly request a hearing upon receiving a basically unintelligible denial. We disagree.

"Good cause" in the context of ORS 656.319(1)(b) means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). Claimant has the burden of proving good cause. Cogswell v. SAIF, 71 Or App 234, 237 (1985).

Here, claimant's explanation for failing to file a request for hearing within 60 days of receiving the denial letter is that she did not understand the meaning of the document because she does not read English. However, we have previously held that failure to take steps necessary to understand mail is substantially the same as refusal to accept mail, and neither constitutes good cause for failing to timely file a request for hearing. Juanita Trevino, 34 Van Natta 632, 633 (1982), citing Evelyn M. Partlow, 32 Van Natta 178 (1981).

Claimant contends that although she physically received the denial letter, she was not notified of the denial at that time because she did not understand the meaning of the document. Claimant argues that she filed a request for hearing within 60 days of notification of the denial, which allegedly occurred when she talked with a school teacher shortly before consulting an attorney. See ORS 656.319(1)(a). We disagree.

Notification occurs, and the 60-day and 180-day periods begin to run, when claimant has either actual or constructive receipt of the denial. SAIF v. Edison, 117 Or App 455 (1992). Here, claimant admitted actually receiving the document some time after October 16, 1991, but before December 1991. Thus, claimant received actual notice of the denial more than 60 days before filing her February 22, 1992 request for hearing. Therefore, in order for the request for hearing to be timely, claimant must prove good cause for failing to file within 60 days of receipt of the denial letter.

Moreover, even if we were to consider claimant's actual receipt of an unintelligible document to be tantamount to constructive receipt, claimant must still prove reasonable diligence. That is, claimant's failure to file a request for hearing based on lack of actual knowledge of a denial is sufficient to establish "good cause" if claimant proves reasonable diligence. See Giusti Wine Co. v. Adams, 102 Or App 329, 332 (1990); Anastacio L. Duran, Sr., 45 Van Natta 71 (1993).

Here, although claimant understood that the denial letter came from the insurer, she apparently did not contact the insurer for an explanation of the document. (See Tr. 8). Although claimant's daughter's teacher had previously assisted her in filing the claim, claimant apparently did not contact the teacher for assistance in understanding the denial letter. (See Tr. 22). Instead, claimant relied solely on her daughter to read and interpret the letter, and her daughter misunderstood the document. (See Tr. 14-16, 23). There is no explanation in the record for why claimant did not contact an attorney before February 6, 1992.

Under these circumstances, we conclude that claimant failed to exercise reasonable diligence. Accordingly, we find that claimant filed her request for hearing more than 60 days after notification of the denial, and that she failed to prove good cause for filing the request more than 60 days but within 180 days after receiving notification of the denial.

Because we have found that the filing of claimant's request for hearing did not satisfy ORS 656.319(1), we do not address the insurer's arguments regarding compensability of the claim.

## ORDER

The Referee's order dated June 11, 1992 is reversed. Claimant's request for hearing is dismissed.

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In the Matter of the Compensation of
**MAXINE V. WILLIAMS, Claimant**
WCB Case No. 91-15472
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a current low back condition. On review, the issue is aggravation. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## FINDINGS OF ULTIMATE FACT

Claimant's August 8, 1990 compensable low back injury remains the major contributing cause of her current low back condition.

Claimant's compensable back condition worsened after July 30, 1991, such that claimant was less able to work thereafter. This worsening is established by medical evidence supported by objective findings.

## CONCLUSIONS OF LAW AND OPINION

Claimant has filed a claim alleging an aggravation under ORS 656.273(1), which provides, in part:

> "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."

There is no real dispute that claimant's low back condition worsened since her injury claim was closed on July 30, 1991. The issue is whether the relationship between that worsening and the original injury is sufficient to establish compensability.

The general rule is that a compensable worsening is established by proof that the original injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). In this case, however, the medical evidence establishes that claimant's worsening is the result of a combination of her compensable injury and her preexisting degenerative back condition. Because the injury combined with a preexisting condition to cause a need for treatment and disability, the appropriate statute for determining the compensability of the worsened condition is ORS 656.005(7)(a)(B). See Bertha M. Gray, 44 Van Natta 810 (1992);[1] Lareta C. Creasey, 43 Van Natta 1735 (1991). Thus, in order to establish an aggravation claim, claimant must first establish that the original injury remains the major contributing cause of the worsened condition.

We agree with and adopt the Referee's reasoning and conclusions that claimant's compensable injury is the major contributing cause of claimant's current condition. Concerning the medical evidence, with the following exception, we provide this supplementation. We do not find that Dr. Thompson changed his opinion without explanation. Nevertheless, we agree with the Referee that the opinion of Dr. Long, current treating physician, is more persuasive than the others, because it is well-reasoned and based on an accurate history. In addition, we note, as did the Referee, that no other medical opinion explains why claimant's back has been continuously symptomatic since her compensable injury.

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 is $450, 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 July 1, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $450, payable by the self-insured employer.

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[1] Although a signatory to this order, Board Member Gunn directs the parties' attention to his dissenting opinion in Thomas L. Fitzpatrick, 44 Van Natta 877 (1992).

In the Matter of the Compensation of
**JAMES P. BAKER, Claimant**
WCB Case Nos. 91-06922 & 91-06153
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Neal's order that declined to award temporary total disability benefits from September 26, 1990 through January 10, 1991. On review, the issue is temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's attending physician had not authorized temporary disability benefits from September 26, 1990 through January 10, 1991, and therefore, claimant had not established that he was entitled to such benefits for that period of time. We agree with the Referee that claimant has failed to prove entitlement to temporary disability benefits during the aforementioned time period. We apply the following analysis.

Although a claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. See Esther C. Albertson, 44 Van Natta 2058 (1992). Rather, a claimant's substantive entitlement to temporary total disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

In the present case, we find that a review of the entire record supports the Referee's conclusion that claimant is not entitled to temporary disability benefits for the period of September 26, 1990 through January 10, 1991. Although claimant contends that Dr. Guyer was no longer his treating physician after September 26, 1990, Dr. Guyer treated claimant since April 1990, and claimant did not come under Dr. Benz's care until November 1990. As found by the Referee, Guyer did review the subsequent reports by Dr. Benz and concluded that there was no objective evidence to support the surgery performed by Dr. Benz. Moreover, Dr. Guyer opined that the type of surgery performed by Dr. Benz was controversial.

We conclude that greater weight should be placed upon Dr. Guyer's opinion than that of Dr. Benz. We agree with the Referee that, as the doctor who treated claimant up until the time he viewed the investigation tapes and reported that claimant could return to regular work, Dr. Guyer is in the best position to determine claimant's disability.

Finally, we note that the Referee found that claimant was not credible, and that Dr. Guyer and other physicians who examined claimant also questioned his credibility. For this reason, we decline to give much weight to the lay testimony offered by claimant.

Accordingly, we conclude that claimant has failed to establish by a preponderance of the evidence that he was disabled during the time period in question due to the compensable injury. We therefore agree with the Referee that claimant has not established an entitlement to temporary total disability benefits for the period of September 26, 1990 through January 10, 1991.

ORDER

The Referee's order dated May 1, 1992 is affirmed.

In the Matter of the Compensation of
**TINA A. JOHNSON-BACHMEIER, Claimant**
WCB Case No. 91-06078
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order that awarded claimant 39 percent (58.5 degrees) scheduled permanent disability for loss of use or function of the left forearm, whereas an Order on Reconsideration awarded no scheduled permanent disability. 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 exception of the last paragraph in that section.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established entitlement to an award of permanent disability for her loss of grip strength which was due to anatomical changes. We disagree.

On October 23, 1990, claimant was examined by her treating doctor, Dr. Stanley, M.D. Dr. Stanley reported that claimant's wound was well-healed and she had full range of motion. Dr. Stanley noted a grip strength of 20 pounds on the left, compared to 90 pounds on the right. He further noted, however, that he was "concerned (about) how much effort she was putting into this test...." He concluded that claimant's sensation was normal and she had no evidence of muscle atrophy. Dr. Stanley reported that claimant could go back to almost all types of work except very heavy, strenuous work. He stated that there would not be much benefit from further treatment for claimant.

A November 6, 1990 SAIF questionnaire was completed by Dr. Stanley. The letter from SAIF noted that loss of grip strength was indicated by the closing exam, and asked whether such loss was due to nerve damage, atrophy or other anatomical changes. Dr. Stanely checked a box indicating that claimant's lost grip strength was not due to any of the listed rateable conditions. Dr. Stanley also checked "no" to a question which asked whether claimant appeared to exert full effort.

Dr. Stanley subsequently completed another SAIF questionnaire which contained the same questions as the November 6 letter. This time, however, Dr. Stanley responded that claimant's loss of grip strength was due to anatomical changes in the form of scar tissue. Dr. Stanley continued to respond that claimant had not exerted full effort and he indicated that she could return to regular work.

Under the circumstances, we are not persuaded by Dr. Stanley's second report, as he has provided no explanation for his change of opinion with regard to the causation of claimant's loss of grip strength. Moreover, we conclude that Dr. Stanley has consistently reported that claimant has not exerted full effort during the grip strength tests. See e.g. Verneda L. Ramer, 43 Van Natta 2389 (1991) (Claimant was unable to prove entitlement to an impairment value where her range of motion was difficult to evaluate because she would not actively go through normal range of motion tests).

Accordingly, we conclude that claimant has failed to show, by a preponderance of medical evidence, that she has established entitlement to an award of permanent disability for loss of grip strength. ORS 656.726(3)(f)(B). We, therefore, reverse the Referee's order.

## ORDER

The Referee's order dated July 14, 1992 is reversed. The Notices of Closure and the May 10, 1991 Order on Reconsideration are reinstated and affirmed.

In the Matter of the Compensation of
**MARY DAVENPORT, Claimant**
WCB Case No. 91-17618
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Claimant has requested reconsideration of our February 17, 1993 Order on Review which affirmed a Referee's order that concluded that claimant had established the compensability of her right knee condition. In that order, we noted that claimant would be entitled to an attorney fee pursuant to ORS 656.382(2) for prevailing over SAIF's request for review. However, we awarded no such fee because we had not received an appellate brief from claimant.

On reconsideration, claimant has provided proof that a brief was timely prepared for filing with the Board, but was inadvertently mailed to SAIF along with SAIF's copy of the brief. SAIF has confirmed that claimant's original brief was in its file. SAIF does not oppose claimant's request for an attorney fee award.

Accordingly, on reconsideration, we conclude that claimant is entitled to an 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 is $700, to be paid by the SAIF Corporation. 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.

Our February 17, 1993 order is withdrawn. Claimant's attorney is awarded $700 for services on review, payable by SAIF. With this modification, we adhere to and republish our February 17, 1993 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEORGE GODDARD, Deceased, Claimant**
WCB Case No. 91-04998
ORDER OF ABATEMENT
Royce, Swanson & Thomas, Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys

Claimant has requested reconsideration of our February 2, 1993 Order on Review. Specifically, claimant objects to that portion of our order which declined to assess a penalty based upon medical bills which remained unpaid at the time of claim acceptance, but which were paid prior to hearing.

In order to allow sufficient time to consider the motion, the above noted Board order is abated. In addition, we seek the parties' respective positions concerning the effect, if any, the following decisions have on this dispute. Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989); Kim S. Jeffries, 44 Van Natta 824 (1992); Linda M. Akins, 44 Van Natta 108 (1992). The parties' responses should be filed within 14 days of the date of this order. Thereafter, we shall take this matter under advisement

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DAVID F. MEISSNER, Claimant**
WCB Case No. 91-04509
ORDER ON RECONSIDERATION
Schneider & DeNorch, Claimant Attorneys
Snarskis, et al., Defense Attorneys

Claimant has request reconsideration of our February 17, 1993 Order on Review. Specifically, claimant seeks an assessed attorney fee pursuant to ORS 656.382(2) for his counsel's services on review. We hold that claimant is not entitled to such an award.

If a request for review is initiated by an insurer and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the insurer shall be required to pay a reasonable insurer-paid attorney fee. ORS 656.382(2).

Here, claimant accurately notes that the insurer requested review of the Referee's order. Nevertheless, the Referee's order did not award compensation to claimant. Rather, the Referee remanded claimant's vocational assistance request to the Director for further action designed to determine whether claimant was likely eligible for vocational assistance. Claimant was not awarded compensation until the issuance of our order, which directed the insurer to provide vocational assistance.

Inasmuch as the Referee's order did not award compensation to claimant, ORS 656.382(2) is not applicable. Instead, as stated in our prior order, claimant's attorney fee for his counsel's efforts in obtaining vocational assistance is payable from the increased compensation created by our order. ORS 656.386(2); Simpson v. Skyline Corporation, 108 Or App 721 (1991).

Accordingly, the request for reconsideration is granted and our February 17, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 17, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**JANE WALPOLE, Claimant**
WCB Case Nos. 91-04699 & 91-03783
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Mitchell, Lang, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld EBI Companies' denial of claimant's occupational disease or "new injury" claim for a fibromyalgia condition; and (2) upheld Giesy, Greer and Gunn's denial of the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last five paragraphs beginning with the last paragraph on page 3. We supplement as follows.

Claimant discontinued her allergy shots in October 1990, a month after she developed hand symptoms.

Although Dr. Kappes initially diagnosed claimant with early osteoarthritis, he noted that claimant was still being evaluated to establish a final diagnosis.

At the same time that Dr. Bennett diagnosed fibromyalgia, he also diagnosed osteoarthritis "which was so mild [he] could not make a positive diagnosis." (Exs. 14A and 19).

Dr. Bonafede diagnosed claimant with clinical evidence of fibrositis and noted that there was no clinical, radiological or isotope scanning evidence to support a diagnosis of early osteoarthritis. (Ex. 28D).

EBI's March 18, 1991 denial of compensability and responsibility was on the basis that claimant's employment as a dentist was not the major contributing cause of her fibromyalgia condition. (Ex. 33).

Giesy, Greer and Gunn's April 12, 1991 denial of compensability and responsibility was on the basis that claimant's fibromyalgia did not arise out of the course and scope of her employment. (Ex. 36)

After his file review, Dr. Fraback diagnosed claimant with fibromyalgia and mild hand osteoarthritis. (Ex. 38A).

## FINDINGS OF ULTIMATE FACT

Medical evidence supported by objective findings establishes claimant's fibromyalgia. Claimant's work as a dentist was the major contributing cause of the disease, which required medical services and resulted in disability.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee concluded both that claimant has hereditary osteoarthritis, which is not subject to a Workers' Compensation claim, and fibromyalgia. The Referee concluded that the fibromyalgia is not related to claimant's work as a dentist. We disagree.

Claimant argues that her fibromyalgia is compensable either as an occupational disease or, alternatively, as an injury.

An occupational disease is distinguished from an accidental injury in that the onset of the former is gradual over a long period of time, rather than within a relatively short, discrete period of time. LP Company v. Disdero Structural, 118 Or App 36 (1993). In addition, an occupational disease is not unexpected but is recognized as an inherent risk of continued exposure to conditions of the particular employment. Valtinson v. SAIF, 56 Or App 184, 187-88 (1982).

The medical evidence establishes that claimant experienced fatigue symptoms and non-refreshing sleep in August 1990. She then experienced acute weakness and hand pain early in September 1990, with musculoskeletal aching developing thereafter. Dr. Bennett, Professor of Medicine and Chairman of the Division of Arthritic and Rheumatic Diseases at the Oregon Health Sciences University (OHSU), explained that claimant's increased work load since March 1990 led to the sleep disorder of August 1990, which nearly always antedates the development of fibromyalgia symptoms. He explained that, given the nature of claimant's work as a dentist, one could predict that the small muscles of her hand would be maximally stressed during dental procedures that would result in hand pain as the first symptom of fibromyalgia. We accordingly conclude that this gradual onset of fibromyalgia is an occupational disease, rather than an accidental injury. Valtinson v. SAIF, supra.

An occupational disease is any disease or infection arising out of and in the course of employment caused by activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment and which requires medical services or results in disability. ORS 656.802(1). Claimant must prove that employment conditions were the major contributing cause of the disease or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

On September 20, 1990, after experiencing two acute episodes of hand weakness and pain while performing dental procedures, claimant sought treatment from Dr. Belknap, her attending physician, for muscular weakness and pain in her hands, her fingers locking in flexion, tingling in her fingers and toes, and pain in the joints of her feet. Dr. Belknap referred her to Dr. Kappes, rheumatologist, who noted that claimant's hands continued to be painful and that the joints 'pinged.' He also noted persistent weakness in claimant's arms and her difficulty in performing dental work. Kappes referred claimant to Dr. Bennett for a more extensive work-up. Although Bennett tentatively diagnosed claimant with hereditary osteoarthritis, it "was so mild [he] could not make a positive diagnosis," and no tests conclusively confirmed such a diagnosis. (See Ex. 39-3). More importantly, Bennett diagnosed fibromyalgia and referred claimant to the OHSU Fibromyalgia Treatment program.

Dr. Bennett based his diagnosis on his findings that claimant had widespread musculoskeletal pain in 11 out of the 18 tender points designated by the American College of Rheumatology's 1990 criteria and that claimant suffered from a non-restorative sleep disorder typical of patients with fibromyalgia. Laboratory tests had revealed that claimant had a low Somatomedin C level, the result of disruption of stage 4 sleep. Bennett explained, "Any condition which can result in a stage 4 sleep disturbance is considered to be critical in the pathogenesis of fibromyalgia. In this respect pain, and the psychosocial sequelae of pain, would be important contributing factors to [claimant's] sleep disturbance." (Ex. 39-3).

Dr. Bonafede, M.D., also evaluated claimant. He too diagnosed fibrositis (fibromyalgia), based on findings of tenderness in a number of specific areas and the sleep disorder. He also noted that there was no clinical, radiological or isotope scanning evidence to support a diagnosis of early osteoarthritis. Dr. Fraback, rheumatologist, also diagnosed fibromyalgia on the basis of his records review. On the other hand, Dr. Turco, psychiatrist, opined that claimant's fibromyalgia was not substantiated by any objective findings. However, given the substantiation of claimant's fibromyalgia by three doctors, including two specialists, we are not persuaded by Dr. Turco's opinion. Accordingly, we conclude that claimant has established the existence of her fibromyalgia by medical evidence supported by objective findings. See ORS 656.802(2).

Both insurers make the argument that claimant's fibromyalgia arose not from claimant's work, but from emotional and psychological problems. The causation of claimant's fibromyalgia is a complex medical question, the resolution of which turns on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259,263 (1986); Uris v. Compensation Dept., 247 Or 420 (1967).

Dr. Bennett opined that claimant's work activities as a dentist were the major contributing cause of the onset of her fibromyalgia. As noted above, he explained that claimant's decision in March of 1990 to be more productive in order to pay off her debts resulted in an increased work load and stress that led to the sleep disorder of August 1990, which nearly always antedates the development of fibromyalgia symptoms. He also explained that claimant's hand pain was due to fibromyalgia involving her interosseus muscles. He further explained that, from the nature of claimant's work as a dentist, one could predict that the small muscles of her hand would be maximally stressed during dental procedures that would result in hand pain as the first symptom of fibromyalgia.

Although Dr. Bennett also noted that the exact etiology of fibromyalgia itself is unknown, his opinion that claimant's work was the major contributing cause of the development of the disease by claimant is supported by a thorough and well-reasoned analysis. Dr. Bennett also opined that claimant's emotional problems developed in response to the loss of her dental practice, an opinion supported by Dr. Deale, claimant's treating psychiatrist, and by the medical records, which show that claimant sought treatment from Dr. Deale in November 1990 for her anxiety and depression of two months' duration and which was related to her concern over the future of her practice and her ability to continue in her profession. (See Ex. 41).

We find the well-reasoned opinions of Drs. Bennett and Deale more reliable than those of Drs. Bonafede, Turco and Fraback. Although Dr. Bonafede diagnosed claimant with fibrositis, he concluded that the cause of her problems were due to psychosocial causes which he admitted he was not qualified to address. He offered no reasoning for his conclusion.

Dr. Turco opined that claimant's fibromyalgia was not substantiated by any objective findings and concluded that her complaints were due solely to underlying unconscious neurotic factors. Given the substantiation of claimant's fibromyalgia by objective medical evidence, as discussed above, the onset of claimant's anxiety after the onset of her physical problems, and the fact that she sought psychiatric treatment for her distress over the impending loss of her practice and profession, we do not find Dr. Turco's opinion persuasive.

Dr. Fraback also diagnosed fibromyalgia, but concluded that it was caused not by claimant's work but was associated with her depression. He stated that his record review did not reveal anything in claimant's job activities that would affect her sleep, aside from depression. There is nothing in the record to indicate that claimant suffered from depression prior to the onset of her acute hand weakness and pain on September 5, 1990. Prior to that time, claimant had been treated for severe allergies, diagnosed in 1989, and which accounted for her earlier complaints of fatigue. Aside from allergy shots, claimant had not sought medical treatment after she received the 1989 allergy diagnosis until she returned to Dr. Belknap for her hand weakness and pain.

Thus, because claimant's emotional difficulties arose subsequent to the onset of the fibromyalgia and impending loss of her profession, and because claimant had increased her work load from March 1990 through September 1990, we also find Dr. Fraback's opinion unpersuasive. Consequently, we conclude that claimant's fibromyalgia is compensable as an occupational disease.

Responsibility

The insurer on the risk at the time claimant became disabled is initially responsible for her fibromyalgia condition. EBI Companies was the insurer on the risk on September 20, 1990, the date claimant became disabled. (See Ex. 19). An insurer that is responsible for a compensable injury or occupational disease remains responsible for continued or increased disability during employment with a later carrier unless the claimant sustains a new injury or occupational disease involving the same condition during the subsequent employment. ORS 656.308(1); Donald C. Moon, 43 Van Natta 2595 (1991). There is no evidence that claimant experienced a new occupational disease or that her condition pathologically worsened after November 1, 1990, when Giesy, Greer and Gunn became the administrator for DBIC. Accordingly, EBI remains responsible for claimant's fibromyalgia.

Claimant is entitled to an assessed attorney fee for services at Hearing and on review. 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 $3,500, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 19, 1991 is reversed in part. EBI Companies' denial is set aside and the claim is remanded to EBI for processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of $3,500, payable by EBI Companies.

In the Matter of the Compensation of
**SHIRLEY D. WARD, Claimant**
WCB Case No. 92-00386
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denial of claimant's injury claim for low back and right knee 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 last paragraph on page 2 and with the following supplementation.

The events at issue occurred on the employer's premises between approximately 2:30 and 2:55 p.m. on Tuesday, September 17, 1991.

## FINDINGS OF ULTIMATE FACT

Claimant's disability and need for treatment for her low back and right knee arose out of and in the course of her employment.

## CONCLUSIONS OF LAW AND OPINION

The sole issue before the Referee was SAIF's denial that claimant's injury arose out of the course and scope of her employment. The Referee concluded that claimant's injury did not occur during the course and scope of her employment because claimant's work shift had ended and was sufficient to end any connection to her employment. We disagree.

Subsequent to the Referee's order, the Court of Appeals issued Boyd v. SAIF, 115 Or App 241 (1992). In Boyd, the court applied the "going and coming rule" or limitation, which provides that injuries sustained while going to and from work are not compensable, unless an exception applies. Boyd, supra, citing Cope v. West American Ins. Co., 309 Or 232 (1990). One of the exceptions to the rule is when the injury occurs on the employer's premises. Id. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable. Id. However, the court held that circumstances may show that if a claimant was engaged in activity of a personal nature, the injury may not be sufficiently work-connected. Id. As an example, it cited Albee v. SAIF, 45 Or App 1027 (1980), in which it held that a claimant who slipped and fell while putting chains on his tires while in his employer's parking lot, was acting outside the course and scope of employment, because he had left work for the day and was putting chains on for personal benefit.

By contrast, in Boyd, the claimant's act of getting into her car at the end of her work shift was not of such a personal nature as to break the work-connection. The employer controlled the parking lot and instructed its employees to park there. In addition, the claimant was simply on her way home from work and had not deviated from that activity prior to her injury.

Here, the employer controlled the rear entrance to its premises. Claimant left by that entrance in order to accept a ride home with a co-worker. Her injury occurred on the employer's premises as she left to go home. We do not find the few minutes claimant socialized with her co-workers after her work shift to be sufficient to break the connection between claimant's work and her injury. Accordingly, we find that claimant has established that her injury occurred during the course and scope of her employment.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. 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 issue is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 4, 1992 is reversed. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**JOHN G. DAVISON, Deceased, Claimant**
WCB Case No. 91-09817
ORDER ON REVIEW
Meyers & Radler, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Barber's order which: (1) assessed a penalty for an allegedly unreasonable delay in paying a nursing home bill pursuant to an earlier referee's order; (2) set aside SAIF's denial of the deceased worker's final hospitalization and burial benefits claim; and (3) assessed a penalty for an allegedly unreasonable delay in paying widow's benefits. In her respondent's brief, claimant (the decedent's widow) contends that the decedent's burial benefits should be based on the law at the time of his death, rather than at the time of his 1962 compensable injury as found by the Referee. On review, the issues are compensability, burial benefits, claim processing, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt the Referee's Ultimate Findings of Fact.

CONCLUSIONS AND OPINION

We affirm and adopt that portion of the Referee's order which found that SAIF unreasonably delayed paying widow's benefits. We reverse the remainder of the Referee's order.

We begin with the Referee's assessment of a penalty based on the nursing home bills. The Referee found that SAIF unreasonably delayed paying the bills which an earlier referee had found compensable. We disagree.

On April 4, 1991, an earlier referee found SAIF responsible for certain nursing home bills. SAIF requested Board review of that order on May 3, 1991. As a result of its appeal, SAIF stayed the payment of the nursing home bills. See ORS 656.313. On June 21, 1991, SAIF advised the Board that it was withdrawing its request for review. On July 18, 1991, SAIF paid the nursing home bills. On July 31, 1991, the Board dismissed SAIF's request for review.

The Board retains jurisdiction to consider a request for review until that request has been dismissed by way of a Board dismissal order. Sharon E. Kelly (VanGorder), 39 Van Natta 467 (1987). Although a withdrawal of a request for review initiates the dismissal process, it is the dismissal order which terminates the Board's appellate review authority under ORS 656.295. Mary J. McFadden, 44 Van Natta 2414 (1992).

Here, SAIF withdrew its appeal on June 21, 1991. Nevertheless, that appeal was not dismissed by the Board until July 31, 1991. As a result of its withdrawal, SAIF certainly could have paid the bill earlier than it did. Yet, the issue is whether SAIF acted unreasonably in not paying the bill until July 18, 1991.

Inasmuch as SAIF's payment of the nursing home bill was provided within 30 days of its withdrawal and nearly two weeks before the Board's order dismissing SAIF's request for review, we do not consider SAIF's conduct to have been unreasonable. Consequently, we reverse the Referee's assessment of a penalty based on nursing home bills.

The Referee also found that the decedent's compensable organic brain syndrome was a material contributing cause of his final hospitalization and death. Therefore, the Referee set aside SAIF's denial of the hospital bill and claimant's burial benefits claim. We disagree.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. ORS 656.005(7); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). On the other hand, when a condition or need for treatment is caused by the compensable injury, a worker must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

Noting that the decedent's chronic brain syndrome has been previously found to be directly related to his compensable 1962 head injury, claimant contends that the decedent's hospitalization and death are compensable because they were materially caused by the chronic brain syndrome. We would agree with claimant's argument if the question was the compensability of the decedent's chronic brain syndrome as related to the 1962 industrial accident. However, the chronic brain syndrome has previously been found to be compensably related to the 1962 work injury. Here, the issue for our resolution is whether the decedent's final hospitalization and death is compensably related to claimant's chronic brain syndrome. Under such circumstances, claimant must satisfy the major contributing cause standard of ORS 656.005(7)(a)(A). Albany General Hospital v. Gasperino, supra. We are not persuaded that claimant has met that burden of proof.

On the decedent's death certificate, Dr. Klubert, the decedent's attending physician, attributed the immediate cause of the decedent's death to coronary atherosclerosis. The certificate further identified as a "significant condition" (a condition contributing to death but not related to the immediate cause), the decedent's chronic brain syndrome. Klubert subsequently explained that claimant's coronary atherosclerosis was a major (51 percent or greater) cause of the decedent's final hospitalization and death. Unable to say to what extent the decedent's organic brain syndrome contributed to his death, Klubert believed that the contribution would "be less than the primary diagnosis of his presumed coronary atherosclerosis."

Based on the attending physician's opinion, it is apparent that the decedent's compensable chronic brain syndrome contributed to his final hospitalization and death. Nevertheless, it is likewise apparent that the noncompensable coronary atherosclerosis condition was the major contributing cause of the hospitalization and death. In light of such circumstances, we are not persuaded that claimant's compensable chronic brain syndrome was the major contributing cause of the decedent's need for medical treatment (hospitalization). Accordingly, we conclude that the claims for final hospitalization and burial benefits are not compensable. In light of these conclusions, we need not address claimant's argument regarding the extent of the decedent's burial benefits.

Claimant has prevailed against that portion of SAIF's appeal which pertains to the Referee's penalty assessment based on widow benefits. Yet, since penalties are not compensation, claimant is not entitled to an attorney fee for her counsel's services on review. Saxton v. SAIF, 80 App 631 (1986).

## ORDER

The Referee's order dated June 10, 1992 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,500 attorney fee awarded to claimant's counsel for services in setting aside SAIF's denial is reversed. The Referee's penalty assessment based on nursing home bills is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**WALTER T. DRISCOLL, Claimant**
WCB Case No. 91-10281
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Crumme's order which dismissed claimant's hearing request for lack of jurisdiction, finding that the Hearings Division did not have jurisdiction to determine whether claimant's claim was disabling until claimant requested reconsideration from the Department of Insurance and Finance's Appellate Review Unit. On review, the issue is jurisdiction and the proper classification of this claim. We reverse.

FINDINGS OF FACT

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

Following his June 1990 left elbow injury, which was accepted as nondisabling, claimant continued to work with no time loss due to his injury.

In June 1991 claimant filed a request with the Department to have his claim reclassified as disabling. By Determination Order dated July 25, 1991, the Department ordered that the injury remain classified as nondisabling. The Determination Order also provided the following notice to parties: "ANY PARTY TO THE CLAIM HAS THE RIGHT TO REQUEST A RECONSIDERATION OR A HEARING FOR A PERIOD OF 180 DAYS FROM THE MAILING DATE OF THIS DETERMINATION ORDER." Claimant requested a hearing on the Determination Order.

CONCLUSIONS OF LAW AND OPINION

Applying the 1990 amendments to the Workers' Compensation Law, the Referee interpreted ORS 656.268(5) and (6) to require a worker to seek reconsideration of all Determination Orders prior to requesting a hearing. Consequently, the Referee concluded that, because claimant failed to seek reconsideration of the Determination Order denying reclassification before requesting a hearing, the Hearings Division lacked jurisdiction to determine the proper classification of claimant's claim. We disagree.

ORS 656.262(6)(c) requires an insurer to advise a claimant of various rights concerning nondisabling injuries, including "the right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon pursuant to ORS 656.268." ORS 656.268(11) provides that a copy of any such determination "shall be mailed to all interested parties in accordance with this section." (Emphasis added.) ORS 656.268(9) provides, in relevant part, that a copy of the determination must be mailed to all interested parties and that "[a]ny such party may request a hearing under ORS 656.283 on the determination."

Thus, the statutes grant to a claimant the right to request a hearing directly from a determination order which resolves the classification issue. There is no statutory requirement that a claimant must first request reconsideration of that determination order. Rather, the requirement that a party first seek reconsideration is limited to closures of accepted, disabling claims.

ORS 656.268(5) provides, in pertinent part:

> "Within 10 working days after the department receives the medical and vocational reports relating to an accepted disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. * * * * 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." (Emphasis added).

Additionally, ORS 656.268(6) sets forth the reconsideration process and provides for an attorney fee on reconsideration.

These provisions do not require a worker to seek reconsideration of all Determination Orders prior to requesting a hearing. Following our review of the statutory scheme and the plain language of the statutes, we find that the reconsideration process set forth in ORS 656.268(5) and (6) is limited to those that are accepted, disabling claims and to Determination Orders that close disabling claims. Therefore, because the Determination Order in the present case relates only to reclassification of an accepted nondisabling claim, claimant was not required to request reconsideration of the Determination Order before requesting a hearing.

In any event, we would find that claimant did request reclassification of his nondisabling claim from the Evaluation Section, as required by ORS 656.262(6)(c) and 656.268(11). In fact, a Determination Order denying reclassification was issued by the Evaluation Section. Consequently, we conclude that claimant exhausted his administrative remedy and the Hearings Division had jurisdiction to determine the "disabling" status of claimant's claim. See Gregory S. Meyers, 44 Van Natta 1759 (1992).

Turning to the merits, we find that a "disabling compensable injury" is one which entitles the worker to compensation for disability or death. ORS 656.005(7)(c). Additionally, a claim is "disabling" if: (1) temporary disability is due and payable; (2) the worker is medically stationary and will be entitled to a permanent disability award under the standards; or (3) the worker is not medically stationary but there is a "substantial likelihood" that the worker will be entitled to an award of permanent disability under the standards once he becomes medically stationary. Former OAR 436-30-045(5).

Here, we find that, after his June 1990 left elbow injury, claimant continued to work with no time loss due to his injury. (Ex. 17-2; Tr. 14-15). Therefore, no temporary disability is due and payable.

Claimant is not medically stationary; therefore, we must determine whether there is a substantial likelihood that claimant will be entitled to a permanent disability award under the standards when he becomes medically stationary. Dr. Hansen, claimant's attending physician, reported that notwithstanding claimant's complaints of intermittent pain in the elbow, he will have no permanent disability from the elbow. (Ex. 19). In the same report, however, Hansen added that claimant has a chronic condition that limits repetitive use of the elbow. (Id.) He explained that claimant has had chronic discomfort with intermittent tingling and that heavy work and frequent repetitions could worsen his elbow discomfort and tingling. (Id.) However, he did not feel that the elbow discomfort would prevent claimant from working as a laborer. (Id.)

Under the standards for rating permanent disability, an award is granted for a scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is "unable to repetitively use a body part due to a chronic and permanent medical condition." OAR 436-35-010(6). Hansen's opinion, while establishing that claimant has a chronic condition in the elbow, does not support a finding that the condition is permanent or prevents claimant from repetitively using the elbow. While speculating that heavy or repetitious work could worsen the condition, he nevertheless anticipates no permanent disability and indicates claimant would be able to continue working as a laborer.

Accordingly, we are not persuaded that there is a "substantial likelihood" that claimant will be entitled to a permanent disability award when he becomes medically stationary. On this record, therefore, we conclude that claimant is not entitled to reclassification of his claim. Consequently, claimant's claim shall remain classified as "nondisabling."

## ORDER

The Referee's order dated December 2, 1991 is reversed. Claimant's hearing request is reinstated. The July 25, 1991 Determination Order denying reclassification is affirmed.

In the Matter of the Compensation of
**MARY M. SCHULTZ, Claimant**
WCB Case Nos. 91-18452 & 91-13000
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The SAIF Corporation requests review of Referee Howell's order that: (1) found that claimant had proved "good cause" for her failure to timely file her request for hearing from SAIF's denial; and (2) set aside its denial of claimant's occupational disease claim for a right and left leg condition. On review, the issue is timeliness and compensability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of his finding that SAIF paid interim compensation to claimant for a period commencing March 18, 1991.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness of Filing of Request for Hearing

In May 1991, claimant filed a claim for a bilateral shin condition. On June 3, 1991, SAIF sent claimant interim compensation for the claim. On June 18, 1991, SAIF denied the claim. On September 12, 1991, claimant filed a request for hearing from the denial.

A request for hearing must be filed no later than 60 days after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, is timely if claimant establishes good cause for the late filing. ORS 656.319(1)(b). "Good cause" within the context of ORS 656.319(1)(b) means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Claimant's explanation for her delay in filing her request for hearing is not entirely clear or consistent. We first note that the parties do not contest the Referee's findings that claimant's check for interim compensation was sent fifteen days before the denial, thereby indicating that claimant received the compensation before the denial. However, claimant testified that she received the denial before the interim compensation, (Tr. 39), and that the receipt of the money caused her to be "confused" about the status of her claim, (id. at 15), and that she regarded it as an indication that SAIF had rescinded its denial, (id. at 39).

In reaching his conclusion concerning "good cause" for claimant's untimely hearing request, the Referee significantly relied on his finding that SAIF had paid interim compensation to claimant for a period commencing March 18, 1991, which is prior to the claim here and, thereby, had confused claimant as to the status of her claim. The Referee presumably based this finding on testimony from a SAIF claims adjuster to that effect. (Tr. 53). On review, SAIF contests this finding, arguing that the testimony is in error. We agree.

First, we note that the date of "injury" for this claim is May 17, 1991 and that the employer first had notice of the claim on May 19, 1991. (Ex. 1). Therefore, the period for which SAIF was obligated to pay interim compensation did not commence until then. Further, the record establishes that claimant did not miss time from work until the middle of May. (Tr. 13-14). Therefore, SAIF would have had no reason to pay interim compensation for any period prior to then. Moreover, SAIF's interim compensation payment totalled $653.58. (Tr. 53). Given claimant's monthly wage of $1,440, it appears mathematically that the period covered by the payment was approximately three weeks rather than the nearly three-month period apparently testified to by the claims adjuster. For these reasons, as well as the fact that claimant has never contended that she was confused by the period of interim compensation paid -- as opposed to the receipt generally of interim compensation -- we agree with SAIF that the claims adjuster's testimony was in error. We, therefore, reject this as a basis for finding that claimant was excusably confused.

Similarly, we are not persuaded that the fact that a prior claim was first denied and then accepted is sufficient to establish legal justification for an untimely filing of a request for hearing on a subsequently denied claim. We are, therefore, limited to the issue involving claimant's alleged confusion arising out of her receipt of interim compensation benefits.

We have previously held that the receipt of interim compensation, either before or at the same time as the receipt of the denial, and any confusion created by this action regarding the status of the claim, is not "good cause." Harold D. Wolford, 44 Van Natta 1779, 1780 (1992); Bonnie J. Santangelo, 42 Van Natta 1979 (1990). We continue to adhere to this holding. In particular, we note that claimant testified that she read and understood the denial. Furthermore, even though she had previously retained an attorney for representation in numerous claims, she failed to contact him until 86 days after receiving the denial to clear up any confusion she had regarding the status of her claim. Therefore, we conclude that claimant failed to prove "good cause" for her failure to timely file her request for hearing. See Cogswell v. SAIF, supra (holding that lack of diligence does not constitute good cause).

Compensability

Because we have found that the filing of claimant's request for hearing did not satisfy ORS 656.319(1), we do not address the compensability of the claim.

ORDER

The Referee's order dated May 27, 1992 is reversed. Claimant's hearing request is dismissed as untimely. The Referee's attorney fee award is reversed.

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March 3, 1993 Cite as 45 Van Natta 394 (1993)

In the Matter of the Compensation of
**MARIANNE L. SHERIDAN, Claimant**
WCB Case No. 91-09220
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Crumme's order that: (1) declined to void or modify a Director's July 30, 1991 order that purported to withdraw a prior Order on Reconsideration; (2) affirmed the July 30, 1991 order and Notice of Closure; and (3) upheld the insurer's partial denial of claimant's current condition. On review, the issues are validity of a Director's order, premature closure, compensability, and extent of scheduled permanent disability. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Validity of Director's Order Withdrawing Order on Reconsideration

We adopt the Referee's conclusions regarding the effect of the Appellate Unit's July 30, 1991 order. Like the Referee, we conclude that the basis for the Appellate Unit's purported withdrawal of the prior Order on Reconsideration, i.e., that the insurer's denial was a retroactive denial, was incorrect. Rather, like the Referee, we conclude that the insurer's denial was no more than a partial denial of claimant's condition subsequent to November 28, 1990. Claimant, therefore, continued to have an accepted condition at the time of reconsideration, thereby vesting jurisdiction in the Appellate Unit to complete the reconsideration process. Like the Referee, we find the July 30, 1991 "withdrawal" order to be tantamount to an "amendment" to the prior Order on Reconsideration, and find that the "amended" order served to simply affirm the Notice of Closure.

We further find, however, that the Order on Reconsideration itself is invalid. Claimant's request for reconsideration specifically disagreed with the impairment findings of her attending physician. The Director, however, did not appoint a medical arbiter prior to the issuance of the Order on Reconsideration.

Under ORS 656.268(7), an Order on Reconsideration is invalid, and we lack jurisdiction to consider a request for hearing from the Order on Reconsideration, if the basis for reconsideration is an objection to the impairment findings and the Director fails to appoint a medical arbiter and submit the arbiter's findings for reconsideration. See Olga I. Soto, 44 Van Natta 697, 700 (1992). As noted, claimant's request for reconsideration specifically objected to the impairment findings used on reconsideration. Because the Director failed to appoint a medical arbiter, the Order on Reconsideration, as amended, is invalid.

Therefore, all issues related to premature closure and extent of permanent disability are not yet ripe for our consideration. Consequently, we vacate those portions of the Referee's order which addressed the premature closure and extent issues.

Compensability of Current Condition

We adopt the Referee's conclusions regarding this issue.

ORDER

The Referee's order dated December 23, 1991 is vacated in part and affirmed in part. Those portions of the Referee's order pertaining to the issues of premature closure and extent of permanent disability are vacated. The remainder of the order is affirmed.

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March 4, 1993 Cite as 45 Van Natta 395 (1993)

In the Matter of the Compensation of
**JAIME BARACIO-ROMERO, Claimant**
WCB Case No. 90-20174
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

On February 18, 1993, we affirmed a Referee's order which found that claimant's claim had been prematurely closed. Review of the Referee's order had been requested by claimant. Notwithstanding our February 18, 1993 order, on February 10, 1993, we had approved a Claim Disposition Agreement (CDA), in which claimant released his rights to workers' compensation benefits (including temporary and permanent disability), except medical services, for his compensable injury. WCB Case No. C2-00053.

In light of such circumstances, claimant has notified us of the withdrawal of his appeal, as well as his request that we dismiss this matter. We treat claimant's submission as a motion for reconsideration. The motion is granted and our February 18, 1993 order is withdrawn.

Inasmuch as this case was presented for review pursuant to claimant's appeal and since claimant has now withdrawn that appeal, we dismiss the request for Board review.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAMES L. CURTIS, Claimant**
WCB Case No. 91-11876
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Neal's order that set aside its partial denial of claimant's preexisting spasmodic torticollis 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

In finding claimant's preexisting spasmodic torticollis to be compensable, the Referee relied on the causal opinion of Dr. Ahlskog, i.e., that claimant's industrial injury was a major contributing cause of an exacerbation of his preexisting condition.

Although claimant agrees with the Referee's decision, he asserts that because his industrial injury caused his preexisting condition to worsen, his claim should be analyzed as a primary consequence of his injury. Thus, citing Albany General Hospital v. Gasperino, 113 Or App 411 (1992), he argues that he need only satisfy the material contributing cause test. We agree with the Referee, however, that because his condition preexisted and combined with his industrial injury to cause an additional need for medical treatment, claimant's burden is to prove that his injury is the major contributing cause of that need for treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

The record contains two opinions regarding causation. Dr. Rosenbaum, a neurosurgeon, examined claimant on behalf of the insurer. He ultimately opined that spasmodic torticollis is of unknown etiology and was not associated with claimant's trauma or work exposure. Rather, he opined that claimant's need for additional surgery resulted from the natural worsening of his preexisting disease process.

Dr. Ahlskog, a consulting neurologist, opined that claimant's work was a major cause of his need for additional medical treatment. While he agreed that most cases of spasmodic torticollis result from unknown causes, he further opined that traumatic injury can be linked to a worsening of the condition. When questioned specifically regarding the relationship between claimant's injury and his preexisting condition, however, Ahlskog prefaced his reply by noting that he could "only speculate" because the cause of the condition is unknown. He then noted that either claimant's work injury or the previous weakening and atrophy of his neck muscles could have provided sensory misinformation to the area of the brain controlling those muscles. Moreover, when specifically asked whether the 1983 injury was "the major contributing cause" of claimant's need for further surgery, Dr. Ahlskog declined to make what he characterized to be an "arbitrary distinction." Rather, because claimant's symptoms recurred after the industrial injury, the doctor opined only that the "accident was the exacerbating factor that led to the worsening of [claimant's] torticollis." Finally, Dr. Ahlskog repeatedly emphasized that the temporal connection between claimant's injury and the onset of his spasmodic torticollis was a critical element of his opinion on causation.

As previously noted, it is claimant's burden to prove that the 1983 industrial injury is the major contributing cause of his current disability and need for treatment. After reviewing the medical evidence, we conclude that Dr. Ahlskog's opinion does not provide the requisite medical opinion in that regard. First, Dr. Ahlskog was unable to opine that claimant's industrial injury was the major cause of his disability or need for treatment. He did state that the injury was "a" major cause, and we recognize that "magic words" are not necessary to establish causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Given the context of Ahlskog's entire testimony, however, we do not find that the requisite "major" causation standard has been established. Ahlskog reported that the causes of spasmodic torticollis are unknown, and while there "can be" a link between trauma and the worsening of spasmodic torticollis, Ahlskog found the distinction between "a" major cause and "the" major cause to be too arbitrary to "deserve a response."

Second, we conclude that Ahlskog's opinion is based largely on the temporal relationship between claimant's injury and the onset of his symptoms. The temporal relationship, however, is, in and of itself, insufficient to establish medical causation. See Allie v. SAIF, 79 Or App 284 (1986). On this record, we conclude that claimant has failed to prove that his preexisting condition is compensable.

ORDER

The Referee's order dated June 29, 1992 is reversed. The SAIF Corporation's partial denial is reinstated and upheld. The Referee's assessed attorney fee award is reversed.

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March 4, 1993 Cite as 45 Van Natta 397 (1993)

In the Matter of the Compensation of
**WILLIAM L. DURBIN, Claimant**
WCB Case No. C3-00253
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Philip H. Garrow, Claimant Attorney
Saif Legal Department, Defense Attorney

On February 1, 1993, 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.

On February 10, 1993, the Board requested an addendum on the CDA to clarify a discrepancy regarding two claim numbers and one date of injury. On March 1, 1993 the Board received the parties' addendum to the CDA. The addendum explained that the CDA was intended to dispose of two claim numbers with one date of injury, as a responsibility issue was currently in litigation and had not been resolved.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any and all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and condition 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 service, in an accepted claim." (emphasis added). See OAR 436-60-005(9).

We note that any denied claim that is pending litigation is a matter in dispute, and thus, cannot be considered to be "accepted." Hence, insofar as SAIF's denial on claim 7737686L represents a denied claim in litigation, that claim is not part of an accepted claim and thus, cannot be disposed of by CDA. See Frederick M. Peterson, 43 Van Natta 1067 (1991).

Although a CDA is not a proper method of disposition under such circumstances, the parties are not precluded from entering into a stipulation whereby claimant withdraws his request for hearing against SAIF's insured. Claimant would then be free to enter into a CDA with regard to the claim that has been accepted on behalf of the noncomplying employer.

Alternatively, claimant and SAIF as the insurer may enter into a disputed claim settlement which settles the denied claim. The remaining amount of consideration may then be disposed of within a re-submitted CDA on the accepted claim.

Accordingly, we find that this release does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the administrative rules. We find such arrangements unreasonable as a matter of law. Randall W. Boggs, 42 Van Natta 2883 (1990).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**JACK A. GABBERT, Claimant**
WCB Case No. 91-15412
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Garaventa's order that upheld the self-insured employer's denial of his claim for treatment of 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

It is undisputed that claimant has a psychological condition which requires medical treatment. Further, the medical record preponderates in favor of a finding that claimant's compensable injury is a material cause of his need for psychological treatment. However, the Referee concluded that, in order to establish compensability of his claim, claimant must prove that his compensable carpal tunnel condition is the major cause of his psychological condition. Moreover, the Referee found that claimant had failed to sustain this burden. We agree that claimant has failed to prove compensability of treatment for his psychological condition. We offer the following analysis.

Although the Referee referred to claimant's claim as one for a "consequential condition," she expressly cited to ORS 656.005(7)(a)(B) as the applicable statutory provision. Because claimant's depressive condition preexisted his compensable carpal tunnel condition, claimant's claim should be analyzed under the "preexisting condition" provision of ORS 656.005(7)(a)(B). Compare Albany General Hospital v. Gasperino, 113 Or App 411 (1992) with Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). In any event, under either provision, claimant is required to prove that his compensable carpal tunnel condition is the major cause of his psychological condition requiring treatment.

On review, claimant argues that this matter involves a medical services claim and, therefore, the appropriate standard for compensability is a material relationship between his compensable injury and his need for treatment. We do not agree. The court's recent decision in Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993), is instructive.

Like claimant here, the claimant in Ferguson suffered from a compensable carpal tunnel condition. The claimant underwent surgery. Shortly after surgery, claimant fell at home and his sutures came out, thereby requiring emergency room repair. The employer refused to pay the emergency room bill, contending that the fall at home, rather than the compensable injury was the major contributing cause of the need for treatment. We rejected the employer's argument, reasoning that claimant did not seek benefits for a "new" compensable injury or disease, but rather he sought further medical treatment for his compensable carpal tunnel syndrome. Sam D. Ferguson, 44 Van Natta 274 (1992). Therefore, we analyzed the matter as a medical services question under ORS 656.245, and we applied the material contributing cause standard.

The employer appealed to the court. On appeal, the court affirmed our order and agreed with our analysis, stating:

> "When claimant fell at home and damaged his sutures, he suffered no new "injury" or condition different from the carpal tunnel syndrome. The emergency room treatment necessary to resuture the wound is compensable under ORS 656.245 as continued medical treatment bearing a material relationship to the compensable carpal tunnel syndrome." Ferguson, supra at 604.

Here, unlike the claimant in Ferguson, claimant is seeking treatment for a condition different from the carpal tunnel syndrome. Claimant here seeks treatment for a depressive condition which is not an accepted portion of his compensable claim. Moreover, claimant does not contest that portion of the Referee's order that found that the psychological condition is not independently compensable. Because the psychological condition is a "new condition" from the compensable carpal tunnel syndrome, we conclude that the Referee correctly applied the major contributing cause standard to determine compensability of treatment for his psychological condition. Further, we agree with the Referee that claimant has failed to sustain that burden.

Dr. Parvaresh, psychiatrist, examined claimant for the insurer and administered an MMPI and a Beck Depression Inventory. Dr. Parvaresh also reviewed claimant's medical records dating back to 1988. Dr. Parvaresh noted that claimant's "overwhelming psychosocial" stressors included separation from his wife, responsibility as a single parent, a move next to his alcoholic mother and stepfather, and total social and emotional isolation. Dr. Parvaresh concluded that the "minor injury of August 25, 1988, particularly in the light of the last nerve studies, could not conceivably be considered a major cause of his underlying psychological problems." Ex. 53-7.

Claimant's treating physician, Dr. Golden, reported that claimant was not a candidate for carpal tunnel surgery, due to his "overwhelming psychologic (sic) factor...." However, Dr. Golden did not provide an opinion with regard to the causal relationship between claimant's injury and his need for psychological treatment.

Although Dr. Golden remained claimant's treating physician, Dr. Holmes, M.D., of the Oregon Pain Center, treated claimant for both his psychological condition and his carpal tunnel/myofascial syndrome. He opined that claimant's injury and subsequent chronic pain syndrome is the major contributor to his depression. (Ex. 43C-2).

We agree with the Referee's conclusion that Dr. Parvaresh has provided the most persuasive opinion on the issue of claimant's psychological condition. Although Dr. Holmes noted that claimant had nonwork-related psychosocial stressors, his reports do not contain any significant discussion of those stressors or their effect on claimant's psychological condition. By contrast, Dr. Parvaresh's January 6, 1992 report contains an extensive discussion of the various stressors to which claimant was exposed. The record contains no response from Dr. Holmes to the report of Dr. Parvaresh. Under the circumstances, we conclude that the record does not establish that claimant's compensable carpal tunnel syndrome is the major contributing cause of his need for psychological treatment.

## ORDER

The Referee's order dated April 3, 1992 is affirmed

In the Matter of the Compensation of
**LIONEL F. HUSTON, Claimant**
WCB Case No. 92-01526
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of that portion of Referee Menashe's order that declined to award unscheduled permanent disability for a jaw injury. In his brief, claimant also requests review of that portion of the order denying his request that the issue of the extent of unscheduled permanent disability be remanded to the Director for adoption of temporary rules amending the standards. On review, the issues are remand and extent of unscheduled permanent disability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last sentence of the second paragraph on page 1, and supplement as follows.

Claimant, age 64 at hearing, drove an oil tanker and delivered oil at the time of injury.

Claimant returned to regular work in February 1991. He was unable to perform the work and was let go a few weeks later. In March 1991, he went to work as a janitor cleaning banks. This is the job he was performing at the time of determination.

## FINDINGS OF ULTIMATE FACT

Claimant was performing modified work at the time of determination. Claimant experienced a 9 percent loss of earning capacity due to the compensable injury.

## CONCLUSIONS OF LAW AND OPINION

Claimant first argues that he has permanent disability not addressed by the standards and states: "The Director should be required to adopt standards to compensate claimant." We interpret this statement as a request that we remand this case to the Director for implementation of the provisions of ORS 656.726(3)(f)(C).

In Gary D. Gallino, 44 Van Natta 2506 (1992), we held that neither the Hearings Division nor the Board have authority to remand an Order on Reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C). Thus, as in Gallino, we lack authority to remand this case to the Director for the adoption of a temporary rule.

Claimant alternatively contends that he should be awarded unscheduled permanent disability based on the provisions of OAR 436-35-420(1)(a), which rates impairment in chewing, and for a chronic condition that limits repetitive use of the jaw.

Finally, claimant contends that SAIF stipulated at hearing that claimant is entitled to the 5 percent chronic condition award he seeks. We agree. (Tr. 10). We, therefore, find that the award should be made.

### Unscheduled Permanent Disability

The applicable standards are those in effect on October 24, 1991, the date the Determination Order issued. Thus, former OAR 436-35-270 through 436-35-440, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Orders 2-1991 and 7-1991.

Claimant's impairment value for a chronic condition is 5 percent.

Claimant, 64 years old at the time of hearing, was a tanker truck driver at the time of injury. Dr. Potter, his attending physician released him to regular work on January 29, 1991. However, he was unable to perform his oil delivery job and was let go a few weeks later. In March 1991, he went to work as a janitor, cleaning banks, which he was performing at the time of hearing. There is no evidence in the record regarding claimant's education.

A determination of unscheduled permanent disability under the standards is made by determining the appropriate values assigned by the standards to the worker's age, education, adaptability and impairment. The education value is obtained by adding the values for formal education, skills and, in certain circumstances, for the lack of a license or certificate related to employment. Former OAR 436-35-300(6). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those two values is then added to the impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

OAR 436-35-290(2) provides for the assignment of a value of 1 for age if claimant is 40 years of age or more and has not been released to, or returned to, regular work or work requiring greater strength than the job at injury. For all other workers, a value of 0 shall be given. Former OAR 436-35-270(3)(c). Because claimant is 64 years of age and has not been able to successfully return to regular work, the appropriate value for claimant's age of 64 years is 1. Former OAR 436-35-290(2).

Formal Education

Claimant has not provided evidence regarding his level of formal education. Accordingly, the appropriate value for this factor is 0. Former OAR 436-35-300(3)(a).

Skills

Assignment of a skills value under former OAR 436-35-300(4) depends upon the jobs the worker performed during the 10 years preceding the "time of determination." Former OAR 436-35-300(4). The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(12).

In this case, the "time of determination" is October 24, 1991, the date the Determination Order issued. Based upon claimant's job performance, the job title describing the job for which claimant met the highest SVP number during the 10 years prior to the time of determination was Truck Driver, DOT # 904.383-010. That job title is assigned an SVP number of 4. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4)(e) (Temp.).

Claimant's total education value is 3, the sum of the values for formal education and skills. Former OAR 436-35-300(6).

Adaptability

The adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity at the time of determination. OAR 436-35-310(1). The adaptability value is obtained from the matrix of values at former OAR 436-35-310(3). Former OAR 436-35-310(1) and (2).

Here, the DOT job title most accurately reflecting claimant's work at the time of determination is janitor. The SCODDOT identifies that job as being in the medium category. Claimant's truck driving job consisted of medium work. Therefore, the appropriate adaptability value is 1.

Calculation of Unscheduled Permanent Disability

Having determined each of the values necessary under the standards, claimant's unscheduled permanent disability may be calculated. The sum of the value (1) for claimant's age and the value (3)

for claimant's education is 4. The product of that value and the value (1) for claimant's adaptability is 4. The sum of that product and the value (5) for claimant's impairment is 9. That value represents claimant's unscheduled permanent disability. Former OAR 436-35-280.

ORDER

The Referee's order dated April 28, 1992 is reversed in part and affirmed in part. That portion of the order that declined to award claimant unscheduled permanent partial disability benefits is reversed. Claimant is awarded 9 percent (28.8 degrees) unscheduled permanent partial disability benefits for the mandible. Claimant's attorney is allowed 25 percent of the additional compensation awarded by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

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March 4, 1993 Cite as 45 Van Natta 402 (1993)

In the Matter of the Compensation of
**DAVID L. JONES, Claimant**
WCB Case No. 91-06745
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

On February 9, 1993, we withdrew our January 13, 1993 order which reversed a Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree. We took this action to retain jurisdiction to consider a proposed stipulation designed to resolve all issues raised or raisable. In taking this action, we further noted that the Supreme Court had denied review of the Court of Appeals' decision in SAIF v. Herron, 114 Or App 64 (1992). 315 Or 271 (1992).

On February 23, 1993, we received SAIF's motion, which seeks "reaffirmation" of our January 13, 1993 order because [t]here is not currently a settlement pending between the parties." Having received no written response from claimant disputing SAIF's representation (and particularly in light of the Supreme Court's denial of review in Herron), we proceed with our reconsideration.

On reconsideration, as supplemented herein, we adhere to and republish our January 13, 1993 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**BRIAN D. SKOKAN, Claimant**
WCB Case No. 91-09515
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

The SAIF Corporation requests review of Referee Brown's order that found that claimant's knee injury claim was prematurely closed. On review, the issue is premature closure. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last sentence of paragraph (4) on page 2, for which we substitute the following. The work tolerance screening report was provided to Drs. Perry and Woolpert. (Ex. 7 and 7-11).

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's right knee claim, which included a lateral and two medial meniscectomies, was prematurely closed by the May 14, 1991 Determination Order. We disagree.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to show that he was not medically stationary as of the date determined in the Determination Order. ORS 656.266; Berliner v. Weyerhaeuser Co., 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question which must be resolved by an evaluation of the medical evidence. Harmon v.SAIF, 54 Or App 121, 125 (1985). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

On March 27, 1991, claimant requested treatment from Dr. Chamberlain, orthopedist. Dr. Chamberlain examined claimant because Dr. Perry, claimant's attending orthopedic surgeon, had no further treatment to offer. In January 1991, when claimant was not yet medically stationary, Dr. Perry opined that additional surgery was inappropriate for claimant's condition. Dr. Perry recommended that claimant be scheduled for an independent medical examination to help clarify his claim. (Ex. 5). Dr. Chamberlain also had no treatment to offer and recommended an independent medical examination, stating that claimant was otherwise medically stationary. (Ex. 6). On April 24, 1991, Dr. Perry concurred with Dr. Chamberlain's opinion. (Ex. 8).

On April 3, 1991, Dr. Lantz, orthopedist, opined that claimant had chronic right knee pain of unexplained etiology. He noted that claimant's pain was not intra-articular and did not involve the meniscus or damage to the ligaments. He further opined that the pain may involve a nerve. He declined, however, to treat claimant further. He recommended exercise, heat, ice, and aspirin, and stated that claimant would benefit from a pain control clinic and return to work program, but did not suggest that these activities would improve claimant's condition. (Ex. 6-A). Accordingly, we do not interpret his recommendations to mean that claimant's right knee condition was not medically stationary.

On April 16, 1991, claimant was independently examined by Dr. Woolpert, orthopedic surgeon. Dr. Woolpert found that claimant had a full range of motion, no significant instability, no joint line snaps or clicks, no significant atrophy, and no effusion. He, like Dr. Lantz, was unable to explain claimant's pain symptoms. He recommended no further treatment and opined that claimant was medically stationary. (Ex. 9-6). On August 30, 1991, Dr. Perry concurred with Dr. Woolpert's report.

Based on this record, we find that at the time of claim closure (May 14, 1991), no further material improvement was reasonably expected from medical treatment or the passage of time. We, therefore, conclude that claimant has failed to prove that he was not medically stationary as of May 14, 1991, the date the Determination Order issued. See ORS 656.266; Berliner v. Weyerhaeuser Co., supra. Accordingly, the July 12, 1991 Order on Reconsideration shall be affirmed.

ORDER

The Referee's order dated November 15, 1991 is reversed. The May 14, 1991 Determination Order is reinstated and the July 12, 1991 Order on Reconsideration is affirmed.

**Board Member Hooton dissenting.**

I disagree with the majority's resolution of the question of premature claim closure, not only as a matter of fact, but as a matter of law. I would agree with the Referee's analysis on this question even though he may have gone beyond the call of duty in his denigration of Dr. Woolpert's report.

The IME report of Dr. Woolpert, (Ex. 9), is inconsistent with the balance of the medical record and is, therefore, of limited reliability. Further, Drs. Perry and Chamberlain have indicated a willingness to concur with anything, a fact which also minimizes the reliability of their concurrence with Dr. Woolpert's analysis.

What the record does establish is that Dr. Perry, as early as November of 1990, indicated that, orthopedically, he had run out of options and that some input was necessary from other medical specialties to come up with a treatment plan that would provide Mr. Skokan with any real chance of relief. (Ex. 3A). Claimant was then seen by Dr. Chamberlain who suggested a carefully supervised physical therapy program and a structured return to work. (Ex. 3B). He agreed that the orthopedic options were at an end. Thereafter, claimant underwent a second knee rehabilitation program with therapy as recommended by Dr. Chamberlain with injections and support by Dr. Perry. Claimant's only improvement was an increase in muscle strength. His pain and disability remained.

Dr. Perry again recommended independent medical evaluation, as did Dr. Chamberlain.

As a consequence of that recommendation, claimant was seen on April 16, 1991 for a work tolerance examination which recommended a work hardening program to increase physical capacities and help insure a return to work. (Ex. 7). On that same day, claimant was examined by Dr. Woolpert, another orthopedist, who, not surprisingly, concluded that he had no treatment recommendations. Dr. Woolpert, though he was provided a copy of the work tolerance report, did not comment on its contents or recommendations one way or the other. (Exs. 9 & 10).

On April 3, 1991, claimant was also examined by Dr. Lantz who stated his opinion that claimant would benefit from a work hardening program. (Ex. 6A). Ultimately, Dr. Perry agreed with that recommendation following a specific request from SAIF. The patient sought admission to such a program, but was not provided authorization because, in the interim, the claim had been closed.

In Scheuning v. J.R. Simplot Co., 84 Or App 622 (1987), the court stated that where a physician recommended a course of treatment that had not been previously attempted, and that treatment had not yet been initiated, the claimant could not be considered medically stationary, because there remained the reasonable anticipation of further improvement with the medical treatment as yet untried. In a case very much like this one, the court found the claim to be prematurely closed and set aside the Determination Order. They found that claimant had met the requisite burden of proof by demonstrating that there was recommended medical treatment as yet untried.

The majority does not dispute that there is medical treatment that has been recommended but remains untried. However, they argue that Dr. Lantz's opinion that claimant would "benefit" from the additional treatment is not the same as suggesting that the treatment would improve his condition. The argument is simply wrong. The work tolerance screening report clearly indicates that the expected benefit is to insure the return to work and to decrease claimant's actual disability as a result of the injury. That is precisely the kind of "material improvement" required by ORS 656.005(17). No medical report in the present record argues, or even suggests, that claimant would not benefit from this additional treatment. The work tolerance screening report and the report of Dr. Lantz are, therefore, uncontroverted in the record.

In these times, when a Determination Order or Notice of Closure can cut off claimant's right to receive medical care, (see ORS 656.245(1)(b)), it is very important that we take seriously the question whether claimant is medically stationary and be cautious in our approach to such claims. I am convinced that there remains a course of treatment that may well benefit this claimant. Consequently, I am convinced that there is an anticipation of further improvement with treatment or the passage of time, with an attendant reduction of disability, and increase in the capacity to perform work. The present result virtually assures that claimant will never receive this treatment. The claimant, his employer, and the State of Oregon as a whole, all suffer as a result of this loss of productivity. I, therefore, must dissent.

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March 4, 1993 Cite as 45 Van Natta 405 (1993)

In the Matter of the Compensation of
**KATHLEEN A. WILFONG, Claimant**
WCB Case Nos. 92-02770 & 91-14341
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of those portions of Referee Bethlahmy's order that: (1) set aside its denial of claimant's aggravation claim for a neck condition; (2) upheld Sedgwick James and Company's denial of claimant's "new occupational disease" claim for the same condition; and (3) excluded Exhibit 40A from the record as substantive evidence. In its reply brief, SAIF contends that because it now allegedly concedes compensability, claimant's counsel is not entitled to an attorney fee on Board review. On review, the issues are evidence, responsibility, and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, as supplemented.

At hearing, Sedgwick James objected to the admission of SAIF's Exhibit 40A on the basis that it was untimely submitted. The Referee sustained the objection. SAIF then offered the exhibit to establish that its denial was not unreasonable when issued. The Referee received Exhibit 40A into evidence for that limited purpose.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

SAIF objects to the Referee's refusal to admit Exhibit 40A as substantive evidence because it was not submitted to Sedgwick James 20 days prior to the hearing as required by OAR 438-07-018(1). We find that the Referee did not abuse her discretion.

SAIF argues that because the exhibit was timely submitted to claimant, it should not have been excluded. OAR 438-07-018(1) provides that "[n]ot later than twenty (20) days before the hearing, the insurer . . . shall provide the claimant and other insurer . . . copies of all documents that are relevant and material to the matters in dispute[.]" (Emphasis supplied). Subsection (4) of the rule provides, however, that at the hearing, the referee may in her discretion allow admission of additional evidence not disclosed as required.

On March 18, 1992, the Workers' Compensation Board issued and mailed a copy of the Notice of Hearing to SAIF. The notice identified Sedgwick James as a party to the proceeding and directed SAIF to "file with the assigned referee all documentary evidence and provide copies to the other parties[.]" Although SAIF argues that at the time of disclosure, the self-insured employer was not a party to this dispute, SAIF has offered no explanation for its failure to timely provide Exhibit 40A to the employer once it became a party. Accordingly, we find that the Referee did not abuse her discretion by limiting the purpose for which Exhibit 40A was admitted.

Responsibility

We affirm and adopt the Referee's reasoning and conclusions with the following comment. SAIF, as the last insurer against whom claimant had an accepted neck claim, has not established that claimant sustained a new compensable injury or new occupational disease involving the same condition while working under the employer's self-insured coverage. Therefore, SAIF remains responsible for medical services and disability related to claimant's compensable neck condition. ORS 656.308(1).

Attorney Fees

SAIF contends that it has conceded compensability on review and that, therefore, claimant's attorney is not entitled to an attorney fee on Board review. First, we conclude that SAIF has never conceded compensability; we note that on page two of its Appellant's Brief, SAIF specifically contends that claimant's claim is not compensable "against SAIF."

Second, both compensability and responsibility were at issue before the Referee. Therefore, by virtue of the Board's de novo review authority, ORS 656.295(6), compensability remains at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992); Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). SAIF's appeal to the Board placed claimant's award at risk. Claimant's attorney was justified in actively participating at the Board proceeding to protect claimant's interests. Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review, payable by SAIF. See International Paper Co. v. Riggs, 114 Or App 203 (1992).

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 is $750, to be paid by the SAIF Corporation. 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 June 25, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**ANNA M. BRAATZ-HENRY, Claimant**
WCB Case No. 90-17716
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Black's order that upheld the self-insured employer's denial of claimant's 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 failed to establish compensability of her psychological condition. We agree.

Claimant contends that her psychological condition developed as a consequence of her compensable low back injury. Accordingly, claimant has the burden to prove that the compensable injury is the major contributing cause of her psychological condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

The record contains two medical opinions which address causation of the psychological condition. Dr. Naffziger, claimant's treating psychologist, has opined that the industrial injury and its sequelae are the major contributing cause of claimant's depressive disorder. Dr. Naffziger further opined that no non-work circumstances were contributing to claimant's psychological condition.

Dr. Holland, psychiatrist, examined claimant in an independent medical examination (IME) for the employer. Dr. Holland diagnosed a somatoform pain disorder. He felt that claimant's depressive disorder was not causally related to the industrial injury. Instead, Holland felt that claimant had a predisposition to develop a somatoform pain disorder which was contributed to by her husband's vocational situation and work assignment out of the country. Holland concluded that non-work circumstances as well as claimant's predisposition were the major contributing cause of the psychological condition.

Subsequent to his report, Dr. Holland was informed that claimant was undergoing marital difficulties and was facing a possible divorce in December 1989. Holland felt that this fact supported his opinion that non-work circumstances as well as claimant's predisposition to a somatoform pain disorder were the major contributing cause of her psychological condition. Dr. Naffziger disagreed with Dr. Holland's diagnosis of a somatoform pain disorder.

We generally give greater weight to the opinion of an attending physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we find persuasive reasons not to defer to Dr. Naffziger's opinion. We find Dr. Naffziger's opinion regarding the lack of contribution by non-work factors to be at variance with the contemporaneous medical records and with claimant's testimony.

In this regard, claimant told Dr. Bonzer on December 11, 1989, that:

> "She is under a lot of stress because her husband is in Johnston Island which is some place in the South Pacific * * * where he works with a private contracting group on an Army installation and he apparently has been out there for a long time. She has two children, 11 and 13, and she states that there is a lot of stress without her husband and without a father and so this sort of makes things a little worse."

December 1989 chart notes from Dr. Rockey further confirm claimant's ongoing marital probems. Claimant admitted that she was considering divorce if her husband did not return. In spite of this confirmation that claimant was undergoing marital difficulties and associated stress, Dr. Naffziger's reports fail to discuss or persuasively explain why these off work stressors did not contribute to claimant's need for psychological treatment in February 1990.

In her August 22, 1990 report, Dr. Naffziger stated: "There are no non-work circumstances contributing to her psychological condition. Her husband had been out of the country for two six month tours of duty and [claimant] was doing just fine. It was her job injury that caused her pain and depression." (Emphasis added). We find Dr. Naffziger's opinion to be contradicted by the records of Drs. Bonzer and Rockey and by claimant's own testimony, which indicate that claimant was suffering from stress due to her husband's absence from the country and from her marital situation in general. Consequently, we do not find Dr. Naffziger's opinion to be persuasive.

Inasmuch as we find Dr. Naffziger's opinion unpersuasive, and in light of Dr. Holland's contrary opinion, we conclude that claimant has not established that her compensable injury is the major contributing cause of her psychological condition.

## ORDER

The Referee's order dated February 10, 1992 is affirmed.

In the Matter of the Compensation of
**MAREE ELLIOTT, Claimant**
WCB Case Nos. 91-15121 & 92-03189
ORDER DENYING MOTION TO DISMISS
Schneider & DeNorch, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Claimant has moved for an order dismissing the SAIF Corporation's (Griffin's Restaurant) request for Board review. Contending that SAIF/Griffin's has not timely filed a request for review of the Referee's original order in accordance with statutory requirements, claimant seeks dismissal of the appeal. We deny the motion to dismiss.

## FINDINGS OF FACT

The Referee's order issued on December 18, 1992. Pursuant to that order (which referred to WCB Case Numbers 91-15121 & 92-03189), SAIF/Griffin's denials of claimant's aggravation claim for a right wrist condition were set aside and SAIF/Sharper Images TV and Electronics' denial of claimant's "new injury" claim for the same condition was upheld. The Referee also assessed a penalty against SAIF/Griffin's for unreasonable claim processing.

On December 29, 1992, SAIF/Griffin's moved for reconsideration of the Referee's order, as well as reopening of the record. On January 6, 1993, claimant responded to the motion. Opposing SAIF/Griffin's requests, claimant asked that the motion be denied without additional appeal rights.

On January 11, 1993, the Referee issued a "Denial of Motion to Reopen and Reconsider," which referred to both WCB Case Numbers. After addressing SAIF/Griffin's factual and legal arguments, the Referee denied the motions to reopen the record and to reconsider the December 18, 1992 order. The Referee's "Denial" further provided that the parties' rights to seek review continued to run from the date of the December 18, 1992 order.

On January 12, 1993, SAIF/Griffin's mailed by certified mail its request for review to the Board. The request included a certificate of service by mail which indicated that copies of the request had been provided to claimant, claimant's attorney, one of the employers (Griffin's), and SAIF/Sharper's attorney. The request (which referred to only one WCB Case Number) stated that SAIF/Griffin's was seeking "Board review of Referee Hazelett's order dated January 11, 1993."

On January 15, 1993, the Board mailed a computer-generated letter to all parties acknowledging the request for review. The letter listed both WCB Case Numbers.

## 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 of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

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

The time within which to appeal an order continues to run unless the order has been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the Referee's January 11, 1993 "Denial of Motion to Reopen and Reconsider" expressly stated that the parties' rights of appeal would continue to run from the date of the Referee's December 18, 1992 order. In light of such circumstances, it is apparent that the December 18, 1992 order was neither "stayed," modified, nor withdrawn by the Referee's January 11, 1993 "Denial."

Thus, in order for jurisdiction to vest with this forum, we must determine whether SAIF/Griffin's request for review constitutes an appeal of the Referee's December 18, 1992 order. We conclude that it does.

The request for review does state that SAIF/Griffin's is seeking Board review of "Referee Hazelett's order dated January 11, 1993." The only document carrying that date is the Referee's "Denial of Motion to Reopen and Reconsider." Yet, pursuant to that decision, the Referee refused to reconsider his December 18, 1992 "order."

In light of such circumstances, we conclude that SAIF/Griffin's intentions in requesting review were obvious. It was seeking Board review of the Referee's December 18, 1992 "order" from which reconsideration had been denied by the Referee's January 11, 1993 "Denial." Inasmuch as the request for review was mailed to the Board within 30 days of the December 18, 1992 order and since copies of that request were timely provided to the other parties, we conclude that we have jurisdiction to consider this matter.

The fact that SAIF/Griffin's request neglected to include one of the two WCB Case Numbers is also not fatal. A party seeks Board review of a Referee's order, not a case number. See Grover Johnson, 41 Van Natta 88 (1989); William E. Wood, 40 Van Natta 999, 1001 (1988). Since we have concluded that SAIF/Griffin's timely requested review of the Referee's December 18, 1992 order, its failure to cite one of two WCB Case Numbers does not alter our conclusion that jurisdiction has vested with this forum.

Finally, we note that the other employer to this proceeding (Sharper) was apparently not forwarded a copy of SAIF/Griffin's request for Board review. Nevertheless, SAIF/Sharper's attorney was mailed a copy of that request. In the absence of a showing of prejudice to a party, timely service of such a request on a party's attorney is adequate compliance with ORS 656.295(2). See Argonaut Insurance v. King, supra; Nollen v. SAIF, supra; Allasandra O'Reilly, 40 Van Natta 1180 (1988). Moreover, the Board's acknowledgment letter was mailed to all parties to this proceeding (including Sharpers) on January 15, 1993, which is within 30 days of the Referee's December 18, 1992 order. Such circumstances establish that Sharpers received timely notice of SAIF/Griffin's request for Board review.

Accordingly, we deny claimant's motion to dismiss. Consequently, a revised briefing schedule shall be implemented. SAIF/Griffin's appellant's brief shall be due 21 days from the date of this order. Claimant's and SAIF/Sharper's respondent's briefs shall be due 21 days from the date of mailing of SAIF/Griffin's brief. SAIF/Griffin's reply brief shall be due 14 days from the date of mailing of the latest timely mailed respondent's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
**WILLIAM F. GILMORE, Claimant**
WCB Case Nos. 91-04989 & 91-04663
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband, Brazeau, and Gunn.

Claimant requests review of Referee McCullough's order that upheld the self-insured employer's denials of claimant's aggravation and new injury claims for a current right knee 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.

## FINDINGS OF ULTIMATE FACT

Claimant's March 4, 1991 right knee injury occurred within the course and scope of his employment.

Claimant's March 4, 1991 right knee injury was a material cause of his subsequent disability and need for treatment for his right knee.

## CONCLUSIONS OF LAW AND OPINION

### New injury claim

#### Legal causation

The Referee found that claimant's new injury claim fails because claimant did not establish a sufficient work relationship between his parking lot injury and his employment.

Since the Referee's order, the Court of Appeals decided Boyd v. SAIF, 115 Or App 241 (1992), applying and interpreting the "parking lot exception" to the "going and coming" rule, as these rules exist under the case law. Following the court's guidance in our review, we are compelled to reverse the Referee's order in this case.

In Boyd, supra, the injury occurred while the worker was climbing into her car to leave work after finishing her shift. This happened in a parking lot controlled by the employer, where employees were instructed to park. 115 Or App at 243-44. When she started to get into her car, her knee twisted, she heard a popping sound and experienced immediate pain. On these facts, the court found a work-connection sufficient to support the conclusion that the injury arose within the course and scope of the worker's employment and the claim was compensable. Id. at 245.

Here, as in Boyd, claimant injured his right knee while climbing into his car to leave work shortly after completing his shift. As he was trying to slide into the seat of his car, he felt his right knee grab or lock, followed by immediate excruciating pain. It is undisputed that the employer owns and maintains the parking lot where the injury occurred. (See Tr. 42). Although claimant parked regularly in the lot, there is no evidence indicating whether or not claimant was instructed to park there. (See id).

The only difference between the facts in this case and those in Boyd is the absence here of evidence that claimant was instructed to park where he did. However, based on the Boyd court's reasoning, we conclude that this difference is not material to the outcome. The court stated: "The fact that the injury occurs on employer-controlled premises while the employee is traveling to and from work makes the incident sufficiently work connected." 115 Or App at 244. Inasmuch as these requirements are met in the present case, we conclude that claimant has proven a work relationship sufficient to establish legal causation. See ORS 656.005(7)(a).

Medical causation

The medical evidence establishes that the March 4, 1991 parking lot incident was a material cause of claimant's subsequent disability and need for treatment for his right knee. (See Exs. 22, 26 & 27). Consequently, claimant's injury claim is compensable. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Aggravation claim

We adopt the Referee's "Opinion and Conclusions" on this issue, which appear on pages 7 and 8 of the Opinion and Order.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of his new injury claim. 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 review concerning the compensability of the new injury claim is $1,600, 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 the hearing record and claimant's supplemental authorities), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1992 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's denial of claimant's new injury claim is reversed. The employer's denial is set aside and the claim is remanded for processing according to law. For his services at hearing and review concerning the new injury claim, claimant's counsel is awarded an attorney fee of $1,600, payable by the employer. The remainder of the order is affirmed.

**Board Member Gunn, specially concurring:**

Although I concur with the majority's decision, I write separately to express my concerns over the court's broad interpretation of the parking lot exception to the going and coming rule in Boyd v. SAIF, 115 Or App 241 (1992).

Under the Boyd decision, upon which we base our decision in the present case, compensability is tied almost exclusively to the location of the injury. Thus, almost any injury which occurs in an employer owned or controlled parking lot is compensable. This is so, regardless of the fact that the causal connection between the injury and the employment may be remote or nonexistant.

This broad interpretation of the parking lot exception is inconsistent with prior precedent which has required that an on-premises injury have some connection with work in addition to the requirement that the injury occur within the time, place and circumstances of the employment. See, e.g., Carr v. US West Direct Co., 98 Or App 30 (1989). As the court stated in Carr:

> "An employer is not subject to the workers' compensation law for all injuries to an employee irrespective of the cause merely because the employee is injured while working at the place of employment. There must be some causal link between the occurrence of the injury and a risk associated with the employment."

In the present case, as in Boyd, the Board has allowed the "in the course of" element alone to control compensability of the claim, rather than weighing both factors in making the compensability determination. In each case, the claimant was merely getting into his or her car at the end of the day to go home. The injuries were not caused by any hazard related to the employer's parking lot or by any risk of the employment. I am troubled by both the inconsistency of this holding with prior precedent and the potential effects of such broad liability on workers and employers.

Such a broad interpretation of the parking lot exception will result in disincentives to employers to provide safe parking to employees and will encourage employers not to allow employees to use facilities controlled or owned by the employer. Under this interpretation of the law, the mere fact that

the employee was located on an employer owned or controlled area will determine whether or not the claim is compensable without regard to the "arising out of" element. This potential side effect of the Boyd decision is not in the interests of either the worker or the employer. In today's workplace, employers are providing child care and employee fitness facilities in the workplace. This ruling will place a chilling effect on the employer to allow those activities at the workplace. As a former union negotiator, I know property liability questions are paramount in employers' considerations to allow such facilities in the workplace.

The Boyd decision is also inconsistent with other "parking lot exception" cases where the claimant's injury has traditionally been caused by some hazard on the controlled area. For example, in Montgomery Ward v. Cutter, 64 Or App 759 (1983), the claimant sustained a compensable injury when she fell in a hole in the parking lot over which the employer exercised control. Likewise, in Montgomery Ward v. Malinen, 71 Or App 457 (1984), the claimant was compensably injured while returning to work from jury duty when she fell on an ice covered sidewalk which was under the employer's control. In both Cutter and Malinen, the injuries were caused by some hazard on the controlled area that the employer was responsible for. Here, and in Boyd, the injuries did not occur as a result of any hazard or risk of employment. The only connection to work was the location of the claimant when the injury occurred.

In addition, I fail to see a material distinction between the facts of Allbee v. SAIF, 45 Or App 1027 (1980) and Boyd. In Allbee, the claimant hurt his low back while attempting to put chains on his car. The court held that claimant had left work and was on a personal mission when he was injured. I do not agree that there is a distinction between Boyd and Allbee, or for that matter, between Allbee and the present case. The fact that one claimant was putting on chains on his car so that he could go home when the injury occurred, while the other was getting into her car so that she could go home, does not render the latter injury any more work-related, or less personal, than the former. In fact, I would submit that Allbee has a greater work connection than the present case because in Allbee, the injury was apparently caused by an actual hazard in employer's lot (snow or ice), whereas here, the injury was caused by the mere act of the worker getting into his own automobile.

Finally, I believe that the Boyd court's reliance on Cope v. West American Ins. Co., 309 Or 232 (1990) is misplaced. In Cope, the claimant was injured when she was struck by a co-worker's car while walking to work from her car, which was parked in the employer's parking lot. The litigation in Cope arose out of a dispute between the claimant and her automobile insurance carrier over her entitlement to underinsured motorist coverage. The automobile insurance carrier defended on the basis that the claimant's sole remedy was workers' compensation. Thus, entitlement to underinsured benefits was dependent on whether or not the claimant's injury occurred in the course and scope of her employment. However, although a workers' compensation issue was peripherally involved, the real issue before the Cope Court was whether or not there was any genuine issue of material fact such that summary judgment was not appropriate. The Court did not have to decide whether, if the claimant's injury occurred in the parking lot, it was compensable. For this reason alone, I question the Boyd court's reliance on Cope in analyzing the compensability issue.

As a former union official, I am happy for this claimant. As a Board member having the duty to apply the law consistently, as to all claimants, I am confused about where the Board goes from here. Although I am bound to concur with the majority's decision, given the court's decision in Boyd, I would like the Boyd holding to be further clarified by the court to address its apparent inconsistency with prior holdings.

In the Matter of the Compensation of
**WALTER W. GUNIA, Claimant**
WCB Case No. TP-93002
THIRD PARTY DISTRIBUTION ORDER
Burt, et al., Claimant Attorneys

Claimant has petitioned the Board for approval of a third party compromise. ORS 656.587. We approve the settlement.

FINDINGS OF FACT

In October 1990, claimant, an electrician, suffered a compensable injury while moving a piece of machinery. (A Marklift). The incident occurred when the machine overturned into a holding pond. As a result of this incident, claimant suffered neck and back pain, as well as a sinus infection. CNA Insurance accepted the claim and has provided compensation.

In April 1991, when claimant's neck complaints did not subside, Dr. Collada performed an anterior cervical decompression of C5-6. Sinus surgery was performed by Dr. Thompson in September 1991. In October 1991, Dr. Collada released claimant to return to work. Since his return to work, claimant has performed his electrician duties without a reduction in his at-injury wage rate.

The claim was closed pursuant to a September 15, 1992 Determination Order. Claimant was awarded temporary total disability from April 1991 through October 1991. He was also granted 16 percent unscheduled permanent disability.

CNA has incurred $41,947.93 in claim costs. These costs are composed of $18,416.11 for temporary / permanent disability benefits and $23,531.82 for medical expenses.

Claimant retained legal counsel to pursue a third party lawsuit against Ivy Hi-Lift (Ivy), the manufacturer of the Marklift. He filed a complaint, alleging that Ivy was negligent in the following manner: (1) improperly adjusting the brakes on the Marklift; (2) improperly servicing and maintaining the Marklift; (3) failing to warn claimant of the dangers in operating the Marklift in its defective condition; (4) failing to instruct claimant and his fellow co-workers of the required safety adjustments when operating the Marklift on sloping terrain; and (5) failing to warn claimant of the dangers of operating the Marklift on sloping terrain.

Claimant's theory of his cause of action is as follows. Shortly before claimant's accident, a representative for Ivy presented a class for claimant's co-workers regarding adjusting the Marklift's brakes for stopping on level ground. At that class, the representative either by himself or someone under his direction, adjusted the Marklift's brakes. Claimant did not attend that class. Following that class, a co-worker advised claimant's employer that the Marklift (which the employer had been using since 1985) would not slow down and stop properly. A few days later, claimant's accident occurred when he was unable to stop the Marklift while descending sloping terrain. Prior to the accident, claimant had not been warned of the braking problem.

Ivy's defense to the cause of action is based on the following grounds: (1) any improper brake adjustment was made by claimant's employer; (2) claimant's employer failed to properly service and maintain the Marklift since its 1985 purchase; (3) the brakes were properly adjusted following the class; (4) the employer's mechanics failed to warn claimant of the braking adjustment; (5) additional necessary repairs were not performed by the employer's mechanics after the class; (6) the employer failed to remove the Marklift from use following claimant's co-worker's warning regarding the brakes; and (7) following claimant's accident, the Marklift's brake valve was closed, suggesting the possibility that someone had tampered with the valve between the class and the accident.

In addition, Ivy is prepared to assert that claimant contributed to his injuries in the following manner: (1) he was operating the Marklift at an unsafe speed in a higher gear than is appropriate when descending a slope; (2) he did not read the operator's manual or receive any instructions prior to operating the Marklift (the manual warns against steep incline operations); (3) he neglected to take appropriate action to keep the Marklift under control once a problem arose; and (4) although he was aware that the Marklift's lights were not working earlier in the day, he neglected to return the machine for required servicing.

A pretrial settlement conference was held in January 1993. Claimant, his attorney, Ivy, and its counsel were present at the conference convened by a circuit court judge. At the conference, Ivy and claimant agreed to settle the action for $30,000. Wary of the possibility of a comparative negligence finding and the likelihood of some $7,000 in litigation expenses, claimant considers the settlement offer to be appropriate.

Claimant has contacted CNA, seeking its approval of the settlement. Asserting its entitlement to a full recovery of its $41,947.93 lien, CNA has declined to approve the settlement.

Unable to resolve this dispute, claimant has petitioned the Board for relief. Noting that CNA will receive $12,729.57 under a statutory distribution of the $30,000 settlement, she submits that the compromise should be approved.

On January 26, 1993, the Board acknowledged claimant's petition for resolution of this dispute. CNA was requested to submit a response within 21 days of that acknowledgment. No response from CNA has been received within the aforementioned 21-day period.

## FINDINGS OF ULTIMATE FACT

The third party settlement offer of $30,000 is reasonable.

## CONCLUSIONS OF LAW

To begin, Board decisions under the third party law must be made on a record sufficient to sustain judicial review. Blackman v. SAIF, 60 Or App 446, 448 (1982). Here, claimant has submitted a petition and accompanying materials which provide us with adequate information regarding this claim and dispute from which to make our decision. The fact that CNA has not responded to the petition is not fatal to our determination, particularly when CNA has been notified of its option to do so and has not availed itself of that opportunity. We proceed to the merits of this dispute.

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. See Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

After reviewing this record and considering the aforementioned standard, we conclude that a settlement offer of $30,000 is reasonable. We base this conclusion on the following reasoning.

Although claimant's damages resulting from the incident are apparently not a major factor, the liability of Ivy most definitely is disputed. Claimant's allegations regarding Ivy's negligence are serious. Nevertheless, those allegations are countered by Ivy's contentions regarding the various acts and omissions attributable to claimant and his employer. In light of such circumstances, a jury finding of significant contributory negligence is not an unrealistic possibility.

Furthermore, as noted above, CNA's failure to recover full reimbursement for its lien does not mean that the settlement offer is unreasonable. Jill R. Atchley, supra; John C. Lappen, supra. To the contrary, as illustrated by the cases cited above, paying agencies frequently receive less than full satisfaction of their third party lien.

Here, CNA will recover approximately 30 percent of its lien. Although the possibility exists that CNA's recovery could be increased if claimant subsequently obtained a larger third party judgment, it is also possible that the judgment could be less than the present $30,000 settlement. Moreover, CNA's share of any subsequent third party judgment would be reduced by additional litigation expenses incurred in achieving that judgment. As noted in claimant's unrebutted petition, such costs would be significant.

Accordingly, the $30,000 third party settlement is approved. ORS 656.587. Claimant's attorney is directed to distribute the proceeds of that recovery in accordance with ORS 656.593(1).

IT IS SO ORDERED.

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March 5, 1993 Cite as 45 Van Natta 415 (1993)

In the Matter of the Compensation of
**DANIEL E. NELSON, Claimant**
WCB Case No. 92-01592
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests, and the self-insured employer cross-requests, review of that portion of Referee Mills' order that increased claimant's unscheduled permanent disability award for a low back injury from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 9 percent (28.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. When Dr. Bills found claimant medically stationary, he restricted claimant from lifting over 40 pounds. (Ex. 16).

## CONCLUSIONS OF LAW AND OPINION

The Referee applied the standards in effect on the date of the August 5, 1991 Determination Order. (WCD Admin. Order 2-1991). The parties do not dispute the value for impairment (5) assigned by the Order on Reconsideration and adopted by the Referee. The disputes raised on review are the correct value for the adaptability factor and whether claimant is entitled to values for age and education.

### Age and Education Values

The employer argues that claimant is not entitled to values for age and education because claimant was released to regular work. We note that, because claimant is under age 40, he is not entitled to a value for age regardless of whether he was released to regular work. Former OAR 436-35-290(2).

Regarding the question of entitlement to an education value, former OAR 436-35-300(2) provides, in pertinent part, that "[f]or workers who have a physician's release to or returned either to their regular work or work requiring greater strength, the factor of education shall be given a value of 0." For all other workers, the education value is determined pursuant to former OAR 436-35-300(3)-(6). The Referee found that claimant did not return to his regular work and instead returned to light capacity work as a full time grocery checker. We adopt the Referee's reasoning and conclusions concerning this finding.

The Referee also found that the August 28, 1991 release to regular work given by Dr. Bills, claimant's treating orthopedist, was not given on the basis of medical evaluation but rather because claimant requested a full release so that he could return to work. We adopt the Referee's reasoning and conclusions that the record establishes that the release was given for other than a medical purpose. Accordingly, we do not consider the release persuasive evidence that claimant was able to perform his regular duties. See Mike Yochim, 44 Van Natta 1432 (1992) (Board found that a full duty release was not given for medical purposes and thus was not persuasive evidence of claimant's ability to perform regular work). Therefore, we do not find that the release satisfies the requirements of former OAR 436-35-300(2).

Finally, the employer notes that claimant's at-injury job was medium capacity work. Thus, the employer argues, the fifty pound lifting limitation noted in Dr. Bills' March 31, 1992 letter constitutes a release to regular work because such a limit is within medium capacity work. We disagree.

The fifty pound limitation is inconsistent with Dr. Bills' repeated prior limitations of no lifting over 40 pounds. (Exs. 5-4, 16). When Dr. Bills found claimant medically stationary, he noted that claimant had a 40 pound lifting limitation. (Ex. 16). In the March 1992 letter, Dr. Bills noted that claimant continued to have low back symptoms. (Ex. 23). Thus, there is no medical evidence that claimant's condition had improved thereby justifying the increase in lifting capacity. Given this record, we find that the unexplained increase in the lifting limitation is not persuasive evidence that claimant was released to perform his regular work. Thus, we find that claimant is entitled to an education value. We adopt the Referee's reasoning and conclusions regarding his assignment of an education value of 4.

Adaptability

The Referee found that the preponderance of the medical evidence, including evidence after claim closure, indicated that claimant is capable of performing medium capacity work, the same level as his at injury job. Therefore, he concluded that claimant was entitled to an adaptability value of 1. Both parties dispute this value.

The employer asserts that claimant is not entitled to a value for adaptability because, subsequent to the time of determination, claimant's attending physician released him to regular work. We disagree.

In Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992), we concluded that adaptability should be rated at the "time of determination." We based our conclusion on former OAR 436-35-310(1)(a), which states that the impact for the factor of adaptability "is based upon the worker's work status at and before the time of determination[.]" "Time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (now section (12)).

In Heather I. Smith, 44 Van Natta 2207 (1992), we reaffirmed our decision in Libel. In Smith, we acknowledged that ORS 656.283(7) provides that disability is evaluated at the time of the reconsideration order, but we concluded that the intent of ORS 656.283(7) was to permit consideration of a medical arbiter's report during the reconsideration proceeding, not to allow one party to establish that one of the factors involved in determining disability had changed since the claim was closed. George A. Lachapelle, 45 Van Natta 186 (1993).

Where, as here, at the time of determination, the worker has not been released to or returned to regular work or does not have the residual functional capacity (RFC) for regular work, the adaptability factor is determined by a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum RFC at the time of determination. Former OAR 436-35-310(1). The worker's maximum RFC is the greatest capacity evidenced by: (1) the attending physician's release; or (2) a preponderance of medical opinion; or (3) the strength of any job at which a worker has returned to work at the time of determination. Former OAR 436-35-270(3)(d)(A)-(C).

Here, claimant's claim was closed by Determination Order dated August 5, 1991. Former OAR 436-35-270 through 436-35-450 apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Order 2-1991. We rate claimant's adaptability according to claimant's work status at and before the mailing date of the Determination Order. At the time of closure, claimant's attending physician had released him to modified work with no lifting over 40 pounds. (Ex. 5-4, 16). This is the only medical evidence regarding claimant's RFC at the time of determination. Furthermore, at claim closure, claimant had not yet returned to work. Thus, we find that claimant's RFC is in the light/medium category. Former OAR 436-35-270(3)(h); 436-35-310(3). Comparing claimant's at-injury job strength of medium capacity to his RFC of medium/light capacity results in an adaptability factor of 2. Former OAR 436-35-310(3).

Having determined each of the values necessary under the "standards", claimant's unscheduled permanent disability may be calculated. The sum of the value (0) for claimant's age and the value (4) for claimant's education is 4. The product of that value and the value (2) for claimant's adaptability is 8. The sum of that product and the value (5) for claimant's impairment is 13. Accordingly, claimant's unscheduled permanent disability under the standards is 13 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 issue of extent of unscheduled permanent disability is $750, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated May 20, 1992 is modified. In addition to claimant's prior awards totalling 9 percent (28.8 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees), giving him a total award to date of 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased unscheduled permanent disability award granted by this order. However, the total out-of-compensation attorney fee granted by the Referee and Board order shall not exceed $3,800. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid directly to claimant's attorney by the self-insured employer.

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In the Matter of the Compensation of
**MAURICE E. SINGER, Claimant**
WCB Case No. 91-08325
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Hoguet's order that set aside its denial of claimant's injury claim for a cognitive deficit condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction.

Claimant was 58, not 50, years of age at the time of hearing. (See Tr. 35).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion," with the following exception and supplementation.

The insurer argues that Dr. Erickson, treating neuropsychiatrist, was unwilling to state that the July 1989 work injury was the major contributing cause of claimant's cognitive problems. (See Ex. 91-23, 91-29). We agree. Accordingly, we do not adopt the portion of the Referee's opinion (on page 5) indicating otherwise.

It is undisputed that claimant suffers from cognitive deficits, specifically memory loss and concentration difficulties. It is also undisputed that claimant first reported these problems to physicians approximately two months after his July 22, 1989 work injury. The question on review is whether claimant has established that his condition is sufficiently work-related so that it is compensable.

The insurer contends that claimant's memory problems preexisted his compensable injury and therefore, that ORS 656.005(7)(a)(B) requires claimant to prove that his injury is the major contributing cause of the claimed condition. We disagree. In reaching this conclusion, we acknowledge the

uncontroverted testimony of three of claimant's co-workers, reporting claimant's admissions about his pre-injury forgetfulness. (See Tr. 102, 112, 127-29, 150-53, 165-67). However, we also note, as did the Referee, that claimant performed his job without any real memory difficulties until the July 1989 injury. Under these circumstances, including the absence of pre-injury neuropsychological test results, Dr. Erickson concluded that it would be impossible to "judge to what extent claimant's cognitive deficits preexisted his injury." (Ex. 62-2). Because we find no reason to discount Erickson's opinion, we conclude that there is insufficient evidence indicating that claimant had a preexisting "disease or condition," within the meaning of ORS 656.005(7)(a)(B).

In addition, we find that claimant's cognitive deficit condition is not a "consequence of a compensable injury," requiring application of ORS 656.005(7)(a)(A). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). This condition is a consequence of claimant's industrial accident, not his compensable injury. Thus, the claim is not properly analyzed as a secondary or indirect consequence of the injury and claimant need only prove material causation. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, supra.

Dr. Conrad, longtime treating physician, took claimant off work in June 1990, due to claimant's "marked decreased concentration," (see Exs. 33-2 & 34), which Conrad related to the July 1989 work injury. (See Ex. 88-43). Conrad also related claimant's loss of memory to the compensable injury. (Id., see also Exs. 52-2, 55-2). Erickson opined that the injury was a "significant" contributing factor in causing these problems. (Ex. 91-29). Based on the treating physicians' accurate histories (including that concerning claimant's longtime use of alcohol and marijuana), their well-reasoned opinions and Erickson's specialized expertise, we find their conclusions perusasive. Accordingly, we conclude, as did the Referee, that claimant has proven that his cognitive deficit condition is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 $850, 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 June 23, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $850, payable by the insurer.

In the Matter of the Compensation of
**MICHAEL P. YAUGER, Claimant**
WCB Case Nos. 91-10614, 91-07954, 91-12332, 91-10464, 91-06536 & 91-09401
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Davis & Bostwick, Defense Attorneys
Charles Lundeen, Defense Attorney
VavRosky, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Gruber's order that assessed a penalty for an unreasonable denial. AIAC, Kemper, Liberty Northwest, The Travelers, and Scott Wetzel Services have filed respondents' briefs also protesting the imposition of a penalty by the Referee. On review, the issue is penalties. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

In 1986, AIAC, on behalf of Manpower, Inc., was ordered to accept a claim for bilateral carpal tunnel syndrome. Claimant subsequently worked for two other employers, Cloverleaf Painting and Itel Railcar, Inc. In 1991, claimant sought treatment for increased hand symptoms. AIAC denied a claim for aggravation and disclaimed responsibility. SAIF, on behalf of Cloverleaf Painting, denied compensability and responsibility. Kemper, Travelers, and Liberty, all on behalf of Itel, also denied compensability and responsibility. Although Scott Wetzel disclaimed responsibility, it did not deny compensability.

The Referee found that claimant had proved compensability and set aside AIAC's, SAIF's, Kemper's, Liberty's and Travelers' denials of compensability. The Referee also found that AIAC successfully shifted responsibility only for claimant's right carpal tunnel condition to Scott Wetzel and, therefore, set aside Scott Wetzel's disclaimer of responsibility as to the right carpal tunnel condition and set aside AIAC's aggravation denial and responsibility denial for the left carpal tunnel condition. The Referee upheld SAIF's, Kemper's, Liberty's, and Travelers' denials of responsibility.

The Referee also found that all of the denials of compensability were unreasonable. We agree with, and adopt the Referee's conclusion that all of the compensability denials were unreasonable and prevented the designation of a paying agent pursuant to ORS 656.307.

The Referee ordered that AIAC, SAIF, Kemper, Liberty, and Travelers pay a penalty pursuant to ORS 656.262(10) equal to 5 percent of all compensation payable to claimant from the date of disability in July 1991 through the date of hearing. SAIF, joined by Kemper, Liberty, Travelers, and Scott Wetzel, assert that, because those carriers that were assessed a penalty were not found responsible for claimant's condition, there are no amounts "then due" against them upon which to base a penalty. AIAC agrees with this argument and further asserts that, although its aggravation denial was set aside, the Referee's order relieved it of responsibility for benefits for that period from the onset of disability to the date of hearing and, therefore, none of these amounts are due against it as well.

ORS 656.262(10)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refused to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. * * * 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."

The carriers all rely on our decision in David M. Peterson, 44 Van Natta 386, 388 (1992), to support their argument. In Peterson, we upheld a Referee's decision not to assess penalties and attorney fees against a nonresponsible insurer for its failure to send the claimant's attorney a copy of its denial. Reasoning that there were no amounts "then due" against the nonresponsible insurer because the claim was not compensable against that insurer, we found that there was no basis for a penalty pursuant to ORS 656.262(10). Id. In addition, citing Randall v. Liberty NW Ins. Corp., 107 Or App 599 (1991), we found that there was no basis for an assessed fee pursuant to ORS 656.382(1), reasoning that there could be no unreasonable resistance to payment of compensation by the nonresponsible insurer because the claim was not compensable against that insurer. In Randall, the court relied on Ellis v. McCall Insulation, 308 Or 74 (1989), and held that, where a claim is not compensable, there can be no unreasonable resistance to payment of compensation and, therefore, no entitlement to attorney fees. Randall, supra at 117 Or App 604.

Subsequent to our decision in David M. Peterson, supra, we decided Harold R. Borron, 44 Van Natta 1579 (1992). In Borron, although we upheld the insurer's denial of responsibility for a knee condition, we found that the insurer had unreasonably denied compensability of that condition because there was no evidence that the condition was not work-related. Relying on Kim S. Jeffries, 44 Van Natta 419 (1992), we assessed a penalty against the nonresponsible carrier for this unreasonable compensability denial. We based the penalty on all compensation due from the responsible carrier at the time of the hearing, including medical services. Ben Santos, 44 Van Natta 2228, on recon 44 Van Natta 2385 (1992).

In any event, our decision in David M. Peterson, supra, is contrary to the decision of the Court of Appeals in SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983). In Moyer, the Court of Appeals upheld assessment of a penalty against a nonresponsible carrier for its unreasonable denial of compensability. Id. The court found that the nonresponsible carrier's denial of compensability was unreasonable because the only evidence regarding causation stated that the claimant had sustained a new work related injury. The court also found that this denial resulted in delay of payment of compensation by preventing the designation of a paying agent pursuant to ORS 656.307. Id.

Furthermore, the court rejected the carrier's argument that, even if a penalty could be assessed under former ORS 656.262(9) [now ORS 656.262(10)], there were no "amounts then due" from it as the nonresponsible carrier. SAIF v. Moyer, supra at 503. The court reasoned that the carrier would have it add to the statute the words "from the insurer against whom the penalty is assessed" after the words "amounts then due." The court found that "[n]o authority exists for that construction, and it would defeat the purpose of penalties to encourage insurers to withhold benefits." Id.

We find that the same reasoning applies to the current version of the statute. Thus, a penalty may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent. This penalty may be based on the "amounts then due" from the responsible carrier. Accordingly, we affirm the Referee's penalty assessment.

Finally, we note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 10, 1992 is affirmed.

In the Matter of the Compensation of
**JUDY D. FAIRCHILD, Claimant**
WCB Case Nos. 91-01213, 90-14076 & 90-20679
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Lundeen, et al., Defense Attorneys
Tooze, et al., Defense Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Hartford Insurance Company requests review of those portions of Referee Podnar's order that: (1) set aside its July 3, 1990 and March 19, 1991 denials of claimant's aggravation claim for a current low back condition including bilateral knee symptoms; and (2) found that chiropractic treatment from April 2, 1990 until July 1, 1990 was reasonable and necessary. In its brief, Hartford argues that claimant is foreclosed from litigating the March 19, 1991 denial, because she did not request a hearing therefrom. On review, the issues are scope of review, compensability, aggravation and medical services. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following exceptions.

We do not find that claimant's 1987 low back strain injury is the major contributing cause of her bilateral knee symptoms or that claimant's compensable condition has worsened since May 30, 1989, the date of claimant's last arrangement of compensation.

We do not find that claimant's current low back degenerative disease is "part of" the accepted low back injury claim.

We do not find that chiropractic treatment rendered after April 2, 1990 was reasonable and necessary.

## CONCLUSIONS OF LAW AND OPINION

### Scope of review

Hartford questioned the Referee's scope of review at the outset of the hearing, arguing that its March, 19, 1991 denial was not properly before the Referee, because claimant requested a hearing from the July 3, 1990 denial only. We disagree.

By its terms, the March 1991 denial is "supplemental," for the express purpose of clarifying the previously appealed July 1990 denial. (Ex.125-1; see Ex. 116). Consequently, the second denial is surplusage and claimant's failure to request a hearing from the latter duplicative denial until the hearing convened does not bar her from litigating issues raised by both denials. See Jean M. Bates, 43 Van Natta 2280, 2284 (1991), aff'd mem Digger O'Dells Steakhouse v. Bates, 115 Or App 757 (1992). Under these circumstances, we conclude that the Referee properly addressed both denials and they are properly before us on review.

### Aggravation

#### Bilateral Knee Condition

Claimant's aggravation claim is primarily based on her contention that her bilateral knee symptoms represent a worsened condition that is causally related to her accepted low back injury. The Referee agreed with claimant's contention and set aside the insurer's denials. We disagree.

In order to prove a compensable aggravation, claimant must show, inter alia, a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be compensable. We determine whether the worker's current condition is compensable and if it is, whether that condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992).

As noted above, claimant's aggravation claim is primarily based on the contention that her bilateral knee symptoms are causally related to her accepted injury. Thus, we first address the compensability of those symptoms. The medical evidence indicates that, to the extent that claimant's bilateral knee symptoms are injury-related, they are an indirect rather than a direct consequence of the work injury. (See e.g., Ex. 116). Accordingly, ORS 656.005(7)(a)(A) applies to this case. Therefore, claimant must prove that her 1987 compensable strain injury is the major contributing cause of her bilateral knee symptoms. See Julie K. Gasperino, 44 Van Natta 1151 (1991), aff'd, Albany General Hospital v. Gasperino, 113 Or App 422 (1992).

The issue of whether claimant's compensable injury is the major contributing cause of her bilateral knee symptoms 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).

Claimant's bilateral knee symptoms did not appear until April 1990 when she was treating with Dr. King, chiropractor. Dr. King opined that these symptoms were a chronic consequence of the injury. Dr. Long, neurologist, who examined claimant on referral from Dr. King, initially opined that claimant's symptoms were of undefined etiology. However, Dr. Long later reported that claimant did not have a specific knee problem independent of her back condition, but had thigh, knee, and calf symptoms that were related to and caused by the industrial injury. In addition, Dr. Nash, neurologist, also reported that claimant's lower extremity symptoms were related to the compensable low back injury.

By contrast, Dr. Dipaola opined that claimant's bilateral knee condition was not related to claimant's industrial injury. Dr. Dipaola is a board-certified orthopedic surgeon who also examined claimant at the request of Dr. King. Dr. Dipaola reported that claimant did not have any evidence of mechanical or postural problems, internal derangement or underlying injury or disease in her knees. Dipaola disagreed with Dr. Long's conclusion that claimant's knee symptoms were referred from the low back injury. He explained that the location of claimant's knee symptoms was not consistent with the level of her low back that had been injured. Dr. Dipaola concluded that, because claimant did not injure her knee during the compensable incident and in light of the lack of objective findings, claimant's compensable injury was not a major contributing cause of her bilateral knee symptoms. In addition to Dr. Dipaola, the Western Medical Consultants also opined that claimant's knee symptoms were not related to the compensable injury.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons for not deferring to the opinion of Dr. King, a chiropractor. Although Dr. King has treated claimant, she referred claimant first to Dr. Dipaola, and then Dr. Long for a consultation with regard to claimant's knee symptoms. Dr. King's opinion is supported by Drs. Long and Nash, but those opinions are conclusory and do not provide persuasive reasoning. By contrast, Dr. Dipaola is an orthopedic specialist experienced with knee injuries. Dr. Dipaola's opinion is very thorough and well-explained. Moreover, his opinion is supported by the Western Medical Consultants. For these reasons, we rely on the well-reasoned opinion of Dr. Dipaola. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant has failed to establish that her compensable injury is the major contributing cause of her bilateral knee condition. Therefore, claimant has not established an aggravation based on her bilateral knee condition.

Current Low Back Condition

In addition to denying claimant's aggravation claim based on a lack of causal relationship between the compensable injury and claimant's bilateral knee condition, Hartford also denied the compensability of claimant's current low back condition. The Referee set aside Hartford's denial. We disagree.

At the outset, claimant contends that her accepted low back condition includes degenerative disc disease. We disagree. Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9); William K. Porter, 44 Van Natta 937 (1992)(Failure to appeal a Determination Order does not constitute acceptance).

Here, the original claim that was accepted was for a back strain. Although claimant had been diagnosed with degenerative disc disease as early as 1987, this condition was never formally accepted. On this record, we cannot conclude that claimant's degenerative disc disease was encompassed by Hartford's acceptance. See Electric Mutual Liability Ins. Co. v. Automax, 113 Or App 531 (1992).

Turning to the merits, we conclude that claimant has not established that her compensable injury is a contributing factor to her current low back condition. In reaching this conclusion we again find the opinion of Dr. Dipaola and the Western Medical Consultants persuasive. Both Dr. Dipaola and the Consultants opined that the cause of claimant's current low back symptoms are unknown, but cannot be attributed to claimant's relatively minor compensable strain injury. Although Drs. King and Long attribute claimant's current low back condition to the compensable injury, both opinions assume that claimant's degenerative disc disease is a part of the accepted injury. There is no persuasive medical evidence that claimant's compensable injury caused or worsened claimant's degenerative disc disease. Moreover, neither opinion adequately addresses the contribution of other factors such as claimant's bulging disc at L5-S1, mild thoracolumbar scoliosis, moderate to marked lumbar scoliosis, degenerative disc disease, segmental joint dysfunction in the sacroiliac joint, genu valgus deformity, genu recurvatum, lower extremity pronation and a 10 millimeter leg length discrepancy.

Accordingly, we conclude that claimant has failed to establish that her current low back condition and need for treatment is compensable.

Medical services

Inasmuch as claimant's current condition is not compensable, we do not reach the reasonableness and necessity of the claimed chiropractic services.

ORDER

The Referee's order dated October 29, 1991 is reversed in part and affirmed in part. That portion of the order that set aside Hartford's denials is reversed and the denials are reinstated and upheld. Hartford is not responsible for claimant's chiropractic treatment from April 2, 1990 until July 1990. The Referee's $3,000 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

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March 5, 1993 Cite as 45 Van Natta 423 (1993)

In the Matter of the Compensation of
**ALAN G. HERRON, Claimant**
WCB Case No. 90-13623
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Herron, 114 Or App 64 (1992), rev den 315 Or 271 (1992). The court has reversed our prior orders, Alan G. Herron, 43 Van Natta 267 (1991), on recon 43 Van Natta 1097 (1991), which directed the SAIF Corporation to pay claimant's scheduled permanent disability at a rate of $305 per degree. Concluding that claimant is entitled to be paid scheduled permanent disability at the rate in effect as of the date when he was injured, the court has remanded for reconsideration.

In our prior order, we concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. We reasoned that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. The court has reversed our decision, concluding that the legislature intended the increased rate of compensation to apply only to injuries that ccurred on or after May 7, 1990. SAIF v. Herron, supra. Consequently, the court has reversed our prior order and remanded for reconsideration.

Here, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the June 1989 compensable injury. ORS 656.202(2); former ORS 656.214(2).

Accordingly, on reconsideration of our prior orders, we reverse the Referee's order dated August 27, 1990. Claimant's scheduled permanent disability award shall be paid at the rate in effect at the time of his June 1989 compensable injury.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAMES A. DENNY, Claimant**
WCB Case No. 92-12381
ORDER OF DISMISSAL
Pozzi, et al., Claimant Attorneys
Breathouwer, et al., Defense Attorneys

Rebecca Street, registered physical therapist, requests review of Referee Emerson's order which dismissed claimant's hearing request from a Director's Order Concerning a Medical Fee Dispute. We have reviewed the request to determine whether we have jurisdiction to consider the request. We dismiss the request.

## FINDINGS OF FACT

On September 9, 1992, the Director issued an order concluding that neither the self-insured employer nor claimant were responsible for the payment of certain medical services provided by Ms. Street. Claimant requested a hearing from that order.

On February 4, 1993, the Referee dismissed the request, concluding that the Hearings Division lacked jurisdiction over the medical fee dispute. See ORS 656.248(13); 656.704(3). On February 26, 1993, the Board received Ms. Street's request for review of the Referee's order.

## 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 of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20). A physician is not a "party." Stephanie A. Gee, 41 Van Natta 2324 (1991), on recon 42 Van Natta 47 (1992); Karen K. Van Santen, 40 Van Natta 63 (1988).

Here, Rebecca Street, a physical therapist, has requested Board review of the Referee's order. Ms. Street is a medical services provider, not a physician. Nevertheless, she is neither the injured worker, the employer, nor its insurer/claim processor. Consequently, Ms. Street is not a "party." ORS 656.005(20).

Under such circumstances, we lack jurisdiction to consider the request for Board review of the Referee's order. Accordingly, we dismiss the request for review.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**STEVEN S. EWEN, Claimant**
WCB Case No. 91-07052
ORDER ON RECONSIDERATION
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Claimant has requested reconsideration of our February 11, 1993 order that awarded additional temporary disability and assessed a penalty for unreasonable claim processing. Contending that our decision contains some factual errors and asserting that he is entitled to an increased penalty, claimant asks that we withdraw our prior order for further consideration.

The self-insured employer has petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). However, the 30-day period within which to withdraw and reconsider our order has not expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, we retain jurisdiction to consider this matter.

After review of claimant's request, we adhere to the conclusions reached in our February 11, 1993 order. Nevertheless, we make the following modifications and supplementations.

In our prior order, we found that claimant was entitled to temporary disability (less wages earned and previously paid temporary disability) extending from the date of an appealed referee's order (May 3, 1991) until such compensation could be lawfully terminated. In reaching this conclusion, we noted that claimant left work in June 1990 for a reason unrelated to his compensable injury, but was subsequently released from working as a result of his compensable injury in October 1990.

Claimant objects to this latter finding, asserting that he is also entitled to temporary disability for the June 1990 - October 1990 period. Rather than resolve this dispute, we withdraw the finding. We take such an action because the finding is not essential to our conclusion.

As expressly stated in our order, the question before us was the amount of post-May 3, 1991 temporary disability due claimant as a result of the earlier referee's order. Inasmuch as pre-litigation order temporary disability could be withheld pending appeal of the May 3, 1991 referee's order, claimant's entitlement to temporary disability between July 1990 and October 1990 was irrelevant to our decision.

What was relevant to our decision was whether claimant was disabled as a result of a compensable condition as of the May 3, 1991 order and whether any of the events set forth in ORS 656.268(3) had subsequently occurred prior to the hearing in this case to justify the termination of temporary disability benefits. Since claimant's October 5, 1990 work release from his psychologist (Dr. Kohen) remained unaltered and none of the statutory "unilateral termination" events had occurred prior to the May 3, 1991 appealed referee's order, we found that claimant was entitled to post-May 3, 1991 temporary disability.

In light of such a conclusion, whether claimant was or was not disabled as a result of his compensable condition between June 1990 and October 1990 was not essential to the outcome of our determination. Consequently, our "finding" regarding this question is withdrawn.

Claimant also notes a typographical error in our order, noting that we referred to an August 19, 1992 aggravation denial, when the denial was actually dated August 19, 1991. We recognize this clerical error and correct the oversight by this reference.

Finally, claimant seeks reconsideration of our assessment of a penalty for temporary disability due between the May 3, 1991 referee's order and the date of hearing. Specifically, claimant contends that the penalty should be based on temporary disability due subsequent to the date of hearing, until the date the employer eventually provides the benefits.

We are without authority to assess such a penalty. Rather, our authorization extends to amounts then due. ORS 656.262(10); Weyerhaeuser Company v. Knapp, 100 Or App 615 (1990). Here,

"then" refers to the date of hearing, the final day that evidence was presented regarding the employer's processing of this claim. To grant claimant's request and assess a penalty based on post-hearing temporary disability would fail to give effect to the word "then." Weyerhaeuser Company v. Knapp, supra.

Accordingly, we withdraw our February 11, 1993 order. On reconsideration, as modified and supplemented herein, we republish our February 11, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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March 8, 1993 Cite as 45 Van Natta 426 (1993)

In the Matter of the Compensation of
**CAROL KNODEL, Claimant**
Own Motion No. 92-0655M
OWN MOTION ORDER
EBI Companies, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for her compensable low back injury. Claimant's aggravation rights expired on January 27, 1987. The insurer issued a denial of the compensability of claimant's current condition on January 11, 1993. In addition, the insurer opposes the reopening of the claim on the ground that no surgery or hospitalization has been requested.

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 interpret "surgery" to be 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 had two epidural steroid injections at St. Vincent Hospital. However, there is no persuasive evidence in the record that the epidural steroid injections, in and of themselves, resulted in or were likely to result in temporary disability. Accordingly, these injections do not qualify as "surgeries" within the meaning of ORS 656.278(1)(a). Moreover, because the injections were done on an outpatient basis and did not require an overnight stay in the hospital, we do not regard the procedure as "hospitalization" sufficient to justify claim reopening. Fred E. Smith, supra.

Accordingly, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim. Accordingly, we deny the request for own motion relief. Id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JOSEPH A. MOONEY, Claimant**
WCB Case No. 92-03549
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Daughtry's order that: (1) awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for each leg, whereas an Order on Reconsideration awarded no scheduled permanent disability; and (2) awarded claimant 8 percent (25.6 degrees) unscheduled permanent disability for his low back condition, whereas an Order on Reconsideration awarded no unscheduled permanent disability. In his brief, claimant contends that he is entitled to an additional award of scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability. We reverse.

## FINDINGS OF FACT

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

Claimant's compensable injury to his mid and upper back and tailbone occurred on July 25, 1989. Prior to his injury, claimant had sustained low back injuries in 1987 and 1988.

On January 17, 1990, claimant injured his pelvic area. Following his injury, claimant received treatment for his low back. His claim was accepted for a lumbosacral strain and a December 3, 1990 stipulated settlement awarded 9 percent unscheduled permanent disability.

On February 27, 1990, claimant injured his neck and mid back on both sides, while trying to restrain a patient.

In August 1990, claimant injured his neck and left shoulder.

In June 1991, claimant injured his left hip, low back and left heel. His 1991 injury led to increased low back pain.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established rateable impairment due to the compensable 1989 injury. We disagree.

On August 20, 1991, an IME exam was performed by Dr. Burr and Dr. Bolin. Dr. Bolin, a chiropractor, had previously treated claimant. The IME's reported that claimant had no objective findings of residual, with all findings being subjective. The IME's concluded that, because there were no objective findings, there was no way claimant's subjective complaints could be related to his new injuries or other past injuries.

On November 19, 1991, claimant's counsel wrote to Dr. Danner, claimant's treating physician, and informed him that he represented claimant with "reference to a July 25, 1989 industrial injury." Claimant's counsel requested Dr. Danner's description of claimant's impairment as of the last exam on or prior to the date of closure. In response, Dr. Danner checked boxes pertaining to claimant's work restrictions and filled in boxes with range of motion findings. The letter from claimant's counsel also contained a postscript informing Dr. Danner that although claimant had several industrial injuries, a report was only requested with regard to the July 25, 1989 injury.

We conclude that, without further evidence, it is unclear whether Dr. Danner considered only claimant's July 1989 injury in rating claimant's disability. Furthermore, even if Dr. Danner considered only the 1989 injury, his "check-the-box" response contains no explanation as to why he attributed all of claimant's impairment to his 1989 injury, rather than to the prior injuries or the injuries claimant incurred subsequent to the 1989 injury. Consequently, considering the multiple injuries and the lack of

a medical report which establishes that claimant's impairment is due to the compensable injury, see e.g. Robert G. Smith, 43 Van Natta 1667 (1991), we conclude that claimant has failed to establish his impairment by a preponderance of medical evidence based upon objective findings. ORS 656.268(7). Accordingly, the Referee's order is reversed.

ORDER

The Referee's order dated July 6, 1992 is reversed. The Determination Order and March 4, 1992 Order on Reconsideration are reinstated and affirmed.

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March 9, 1993 Cite as 45 Van Natta 428 (1993)

In the Matter of the Compensation of
**DEREK J. SCHWAGER, Claimant**
WCB Case No. 90-19402
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Claimant requested reconsideration of our July 22, 1992 Order on Review, which concluded that his "new injury" claim was barred by principles of res judicata. On August 20, 1992, we abated that order to allow sufficient time to consider the motion. We now proceed with our reconsideration.

In our prior order, we concluded that claimant's "new injury" claim could have been asserted with his prior "aggravation" claim, because both theories of compensability arose from the same set of operative facts. In his request for reconsideration, claimant argues that our conclusion was in error, because he is "now seeking compensation for a condition (lumbosacral facet syndrome) for which he has not previously sought compensation." We understand claimant's argument to mean that his "new injury" claim arises from a different set of operative facts, because his lumbosacral facet syndrome is a "different condition."

In Drews v. EBI Companies, 310 Or 134 (1990), the Supreme Court explained claim preclusion as follows:

> "[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e. precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been tried in the first action."

Claimant's argument appears to involve the last portion of the above-quoted provision. He argues that, because the medical evidence at the time of the prior proceeding did not relate his lumbosacral facet syndrome to his July 10, 1989 injury, the compensability of the condition could not have been adjudicated with his prior aggravation claim. The fault with that argument, however, is that there was no change in his condition. Rather, claimant relies solely on a new diagnosis. That is not sufficient. See Proctor v. SAIF, 68 Or App 333 (1984); Chella M. Morton, 43 Van Natta 321 (1991).

On reconsideration, as supplemented herein, we adhere to and republish our July 22, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

**Board Member Hooton dissenting.**

No issue, with the possible exception of responsibility litigation, produces greater confusion in application of the Workers' Compensation Law, than the doctrines of claim and issue preclusion. The original Order on Review in this claim, an Order which I erroneously supported, is reflective of that confusion. It is not, however, limited to the Board or its Hearings Division. The application of these doctrines at the court has also produced orders whose apparent inconsistencies defy rational explanation.

In its resolution of the present dispute, the majority relies upon Million v. SAIF, 45 Or App 1097, rev den, 289 Or 337 (1980). With one significant point of difference, this case seems to apply directly to the present dispute. However, Million is not the only case which bears on the present claim. Million appears to be facially inconsistent with Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560 (1989), and International Paper Co. v. Pearson, 106 Or App 121 (1991). While it is not my intention to require this Board to presume to overrule prior court precedent, it is appropriate to take stock of the wide range of resolutions, and apparent inconsistencies that have characterized the application of the principles of res judicata, and to place any analysis involving these doctrines on the firmest possible foundation.

The Supreme Court has dealt with the question of claim and issue preclusion on several occasions and, unlike the Court of Appeals, has applied the principles consistently. Because that appears to be the firmest foundation for any discussion of the requirements of claim preclusion, I begin there.

In Drews v. EBI Companies, 310 Or 134 (1990) the Supreme Court stated the requirements for the application of claim preclusion as follows:

> "[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred * * * from prosecuting another action against the same defendant where the claim in the second action is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been tried in the first action." 310 Or at 140, (emphasis added).

I have emphasized the single word "and" for a very specific purpose. Because the Court used the conjunctive form "and" rather than the disjunctive form "or", the court emphasized that claim preclusion is only applicable where three distinct requirements are all met. First, the claim must arise from the same factual transaction. Second, the remedy sought must be additional or alternative to the remedy sought in the original litigation. And, finally, the claim must be of such a nature that it could have been tried in the earlier litigation. If a claim meets only one or two of these requirements, claim preclusion cannot apply.

In addition, it is necessary to consider what the Court intended by its use of the term "transaction." Many facts may be of significance in any particular claim for relief. However, all of those facts are not necessarily encompassed within the term "transaction." A "transaction," as that term is used in Drews, refers to the essential facts necessary to establish the liability of the defendant on the claim. The term "operative facts" has the same meaning, and is not extended beyond the essential facts necessary to establish liability. This principle is demonstrated by a somewhat simplistic analogy.

Suppose individual A has an automobile accident with individual B on New Year's Day, in which individual B is apparently at fault. Assume further that there are some facts which would indicate that individual B's conduct reflected a reckless disregard for the safety of others. Assume further that a second automobile accident involving the same parties occurs on Christmas Day of the same year, and that individual B is at fault in the second accident as well. Assume further that both accidents involved injury to the cervical spine. Finally, assume that, after the Christmas Day incident, individual A is diagnosed with a degenerative cervical condition potentially related to trauma. The law of issue preclusion and claim preclusion requires individual A to join all his potential claims from the New Year's Day incident into a single litigation. Consequently, individual A must assert his claim for negligent injury, and any potential claim for punitive damages into a single litigation. He must also assert or waive a claim for the degenerative condition in his neck. However, the Christmas incident is a separate incident giving rise to its own cause of action. The fact that it involves injury to the same body area does not make it necessary for individual A to join these separate incidents into a single litigation, because they are based on separate "transactions," or distinct sets of operative facts.

Workers' compensation litigation presents a more confusing picture because the claim never really ends. An aggravation claim can be brought for five years after the original injury, and medical services claims may be brought at any time. Nevertheless, the "transaction" giving rise to liability is still the set of operative facts that originally gave rise to the claim.

As in the example provided above, a worsened condition may arise from an original injury as an aggravation, or from a subsequent injury or occupational disease. The worsened condition, however, is not the transaction, or operative fact, giving rise to liability.

In Million, the claimant prosecuted an action for medical services as an aggravation of an accepted shoulder claim. Claimant failed in that original litigation to establish that the condition for which surgery was required was related to the accepted claim. Thereafter, claimant sought to show that the condition was compensable as a result of an occupational disease, arising from the sustained effects of the employment with the same employer as the accepted injury.

The claim involved the same relief sought in the earlier litigation. In addition, the second claim, as found by the Court of Appeals, could have been litigated at the time of the original hearing. However, the original hearing involved a claim for injury, a claim whose factual transaction relates exclusively to a single event or a discreet period of time. The factual transaction involved in the second hearing relates to the effects of a sustained employment exposure. It may include the factual transaction involved in the original hearing, but compensability is not based upon or determined by those facts, but rather by the entirety of the series of occurrences that make up the employment exposure.

By clarifying that claim preclusion only applies where all three preconditions are met, the Supreme Court effectively overruled the analysis used by the Court of Appeals in Million, despite the fact that the Supreme Court initially declined to exercise its discretionary review powers in that case, because the court in Million treated the preconditions to claim preclusion as though they were disjunctive. It applied claim preclusion to bar relitigation even though only two of the three preconditions had been met. That same error is made by the Board here.

In this case, claimant experienced a compensable injury to his low back on November 16, 1987, diagnosed as chronic lumbar strain. On July 10, 1989, claimant experienced a second injurious event followed by a worsening of symptoms. Claimant alleged an aggravation of his accepted low back strain, from which he had only just returned to partial employment due to the severity of the November 1987 injury, on the theory that the worsening was a natural consequence of the accepted condition from the earlier injury. Following a hearing, a Referee determined that claimant had failed to establish a worsening related to his accepted claim. Evidence received shortly before the time of hearing indicated that claimant experienced symptoms from a lumbar facet syndrome.

Thereafter, on the basis of evidence developed after the above referenced hearing, claimant now contends that his July 10, 1989 injury with employer worsened the preexisiting lumbar facet syndrome, and the employer is liable for claimant's low back condition, not as a result of the earlier accepted injurious event, but as a consequence of the later event.

The present claim is not based on the same set of operative facts as the prior hearing, since the operative facts establishing liability in the first hearing involve only the original injurious event and the worsening of any condition arising from that event. Indeed, the July 10, 1989 incident is not an operative fact in that litigation, but may be a defense to liability, just as it would be in the analogy provided above. The operative facts establishing liability in the second claim relate only to the July 10, 1989 injurious event.

Even if Million remains good law, that case does not control the outcome here. In Million, the court specifically found that claimant was aware that an alternative claim for occupational disease existed at the time of the litigation on an aggravation denial. Here, the evidence indicates that claimant was unaware of an independent contribution to a pathological worsening, a requirement at the time of litigation under Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), until after the issuance of the Opinion and Order on the claim for aggravation. Despite that fact, claimant sought the opportunity to join the additional evidence in the prior litigation and was denied that opportunity on Reconsideration by the Referee and, eventually, by the Board.

Based on the factors identified in Drews, claimant is not precluded. The claim arises from a separate "transaction." The remedy is additional or alternative to the remedy sought in the earlier litigation. Finally, the nature of the claim is one susceptible of litigation at the time of the prior hearing, but the claim itself could not have been, since it is based on evidence that was undiscovered at the time

of hearing. Indeed, litigation at the time of the prior hearing was prevented by the refusal of the Referee and the Board to allow admittance of the evidence establishing the pathological worsening. Because all three preconditions to preclusion have not been met, claimant is entitled to litigate the employer's liability for the July 10, 1989 incident in a separate proceeding. I apologize to the parties for my prior approval of an inconsistent order, and regret the majority's misapplication of Drews in this Order on Reconsideration from which I must now dissent.

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March 10, 1993 Cite as 45 Van Natta 431 (1993)

In the Matter of the Compensation of
**DIANNE R. CLARK, Claimant**
WCB Case Nos. 91-15930, 91-11669 & 91-11350
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of those portions of Referee Menashe's order that: (1) set aside its denial of claimant's psychological condition as a consequence of a compensable low back injury; and (2) set aside the January 23, 1991 Determination Order and August 26, 1991 Reconsideration Order as premature. On review, the issues are compensability and premature closure.

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

The employer contends that the Referee erred in considering claimant's concerns about termination from her job as a factor in precipitating symptoms of anxiety and depression. The employer cites Elwood v. SAIF, 298 Or 429 (1985), for the proposition that loss of income, fear of termination and termination cannot be considered in occupational disease claims for mental disorders. Moreover, this policy has been codified in ORS 656.802(3)(b).

In Boeing Co. v. Viltrakis, 112 Or App 396 (1992), however, the court held that when a claimant seeks benefits for a mental disorder as a "natural consequence" of a compensable injury, rather than as an independent claim for an occupational disease, ORS 656.802(3) is not applicable. Instead, under ORS 656.005(7)(a)(A), claimant is only required to prove the injury was the major contributing cause of the consequential need for treatment. Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Diana L. Bert, 44 Van Natta 1827 (1992).

The employer also contends that the Referee failed to give proper weight to the opinions of independent examining psychiatrists Turco and Parvaresh. Dr. Turco examined claimant one time. He noted that claimant had no psychological problems to report on the day he saw her. Therefore, believing that claimant had no mental problem, Turco did no testing.

Dr. Parvaresh also examined claimant one time. He noted that claimant was "devastated" by the employer's refusal to "take her back." Notwithstanding the fact that the employer terminated claimant for the stated reason that she was unable to perform the physical demands of her at-injury job, Dr. Parvaresh opined that if claimant's physical injuries had resolved so that she could return to truck driving, then there was no reason to believe that she should have any psychological sequelae. Moreover, although he assumed that claimant did need psychiatric care concerning the issue of her discharge from employment, Dr. Parvaresh deferred to the claims processor to decide the reasonableness of such care.

We do not find Drs. Turco and Parvaresh's opinions, which attribute claimant's psychological problems, if any, to other emotional experiences, and ignore claimant's concerns regarding her termination from employment due to her physical limitations, to be well-reasoned or based on complete and accurate information. Accordingly, we decline to rely on them.

On the other hand, for all the reasons stated by the Referee, we agree that treating psychiatrist Dr. Harrison offers the most persuasive medical opinion regarding the cause of claimant's anxiety and

depression. We accept Harrison's opinion that the major contributing cause of claimant's mental condition is the pain, disability, change in life-style, loss of self-esteem, and loss of income she has experienced as a consequence of the compensable low back injury.

Accordingly, claimant has established the compensability of her mental disorder as a consequence of her compensable low back injury. Further, we agree with the Referee that the Determination Order and Reconsideration Order which failed to consider claimant's compensable psychological condition issued prematurely.

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 is $1,200, 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 issues, and the value of the interest involved.

## ORDER

The Referee's order dated May 22, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

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In the Matter of the Compensation of
**DORIS A. PACE, Claimant**
WCB Case Nos. 91-11308 & 91-06418
ORDER ON REVIEW
Eileen G. Simpson, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of those portions of Referee Myers' order which: (1) found that claimant's October 1990 injury had been accepted as nondisabling; (2) upheld the insurer's "de facto" denial of claimant's aggravation claim for a November 1988 injury claim; and (3) declined to award additional temporary disability. Contending that she timely notified the insurer that her October 1990 nondisabling injury had become disabling, claimant argues that the insurer unreasonably failed to comply with reclassification procedures. On review, the issues are claim processing, temporary disability, 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

The Referee found that the insurer had accepted claimant's October 1990 injury claim as nondisabling. After considering April 1991 letters from claimant's attending physician (Dr. Hartmann), the Referee further concluded that claimant had not filed an aggravation claim concerning the November 1988 claim. Alternatively, the Referee reasoned that claimant had not established a worsening of her compensable condition. Finally, since there had been no worsening, the Referee declined to award additional temporary disability.

Asserting that the insurer neglected to provide notification of her initial October 1990 injury claim's acceptance as nondisabling, claimant contends that the insurer's acceptance is defective. For reasons discussed later, we conclude that the claim was accepted as nondisabling. Nevertheless, claimant is entitled to a review of her challenge to that nondisabling classification. Specifically, we hold that the insurer was required to notify the Director of claimant's claim that the nondisabling injury had become disabling within one year of the injury. See ORS 656.277(1).

On April 4, 1991, which was within one year of claimant's October 1990 injury, Dr. Hartmann authorized 15 days of time loss. Based on this authorization, claimant contends that she made a claim to reclassify her claim from nondisabling to disabling. In response, the insurer alleges that, because claimant did not first exhaust her administrative remedy set forth in ORS 656.277(3)(c), the Board lacks jurisdiction to consider whether the claim should be reclassified.

ORS 656.277 provides in part:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268.

"* * * * *

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

"* * * * *

"(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon[.]"

When a worker files a request with the Evaluation Section under ORS 656.277(3)(c) for a determination of the disabling status of her claim, we lack jurisdiction over such a matter until this administrative remedy is exhausted. See Randy G. Fisher, 42 Van Natta 635 (1990). However, a worker who wishes to reclassify a nondisabling claim may make such a claim to the carrier under ORS 656.277(1). In such cases, although decided by the Director under ORS 656.268, the carrier must first report the claim to the Director.

Because the statute places initial responsibility for determining a claim concerning the disabling status of a claim with the Director, we conclude that the Hearings Division and the Board lack authority to address the merits of the reclassification issue until resolved by the Director. See Lorna D. Hilderbrand, 43 Van Natta 2723, 2722 (1991). Yet, since the Director does not consider the disabling status of a claim until it is reported by the carrier, we further conclude that we can determine whether a worker has made a claim to reclassify or if the carrier has failed to report such a claim to the Director.

Here, because claimant did not object to the classification of her claim and request a determination concerning this issue from the Evaluation Section, ORS 656.277(3)(c) is not applicable. Rather, ORS 656.277(1) applies since Dr. Hartmann notified the insurer within 1 year of the October 1990 nondisabling injury that he had authorized time loss for 15 days. (Ex. 46). See Linda Warner, 43 Van Natta 159, 160 (1991) (medical report indicating that claimant was not released for work qualified as claim to reclassify claim to disabling status). The fact that Hartmann also stated that claimant's condition had not worsened and that the time loss authorization was attributable to a flareup does not alter our conclusion. The statute is premised on a change from nondisabling to disabling status, not a worsening of a compensable condition. See ORS 656.277(1).

Inasmuch as the insurer did not report the claim to the Director, we conclude that the insurer failed to comply with ORS 656.277(1). In accordance with that statute, we direct the insurer to notify the Director. See OAR 436-30-045(1)(a). As a fee for services rendered in this matter, claimant's attorney shall receive 25 percent of the increased compensation resulting from this order, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1).

Contending that the insurer's conduct was unreasonable, claimant seeks a penalty and attorney fee. In response, the insurer asserts that claimant did not raise this issue at hearing. The hearing transcript lends little assistance in resolving this matter. However, following the hearing and before the issuance of his order, the Referee sent a November 8, 1991 letter to each party which listed the issues for resolution. The parties were further advised that any disagreement with those enumerated issues should be directed to the Referee. When no disagreement was registered, the Referee issued his order.

The Referee's clarification letter does not list penalties as an issue. Rather, an attorney fee award under ORS 656.382(1) is identified for alleged unreasonable "de facto" denials of claimant's initial October 1990 injury claim and her subsequent "aggravation" claim for a November 1988 claim. Consequently, we decline to consider claimant's request for penalties.

We next address claimant's attorney fee request regarding a "de facto" denial of her November 1988 claim. For the reasons expressed by the Referee, we do not consider Dr. Hartmann's reports to constitute an aggravation claim because they do not establish a worsened condition. See ORS 656.273(3). In any event, we share the Referee's conclusion that claimant's compensable November 1988 condition has not worsened. In light of such circumstances, we do not consider the insurer's conduct to have been unreasonable. See ORS 656.382(1).

Turning to the alleged "de facto" denial of her October 1990 injury claim, we conclude that claimant was justified in requesting a hearing when she did not receive timely notification of whether her claim had been either accepted or denied. Nevertheless, we are not persuaded that the compensability of the claim was in dispute. Thus, we disagree with claimant's characterization of the insurer's conduct as a "de facto" denial. See Lisa A. Hyman, 44 Van Natta 2516 (1992). Moreover, the preponderance of the evidence supports the Referee's conclusion that claimant's October 1990 injury claim had been accepted. See SAIF v. Tull, 313 Or 449, 454 (1992) (acceptance of a claim is "an issue of fact"). Because claimant's attorney fee request is based on a "de facto" denial of the initial claim and since we have found that the claim was not denied "de facto," we decline her request to award an attorney fee for the insurer's conduct under ORS 656.382(1).

Although not explicitly listed as an issue by the Referee, claimant's attorney fee request could arguably be interpreted to include the insurer's failure to notify the Director of the reclassification claim. As discussed above, we agree with claimant that the insurer was required to take such an action. However, after considering the surrounding circumstances, we do not consider the insurer's conduct to have been unreasonable.

Claimant's October 1990 injury claim primarily pertained to the right elbow and shoulder. Prior to that claim, claimant had suffered a November 1988 low back and right knee claim. Furthermore, in February 1989, she had fallen down a flight of stairs injuring her neck and right knee. These claims had resulted in a December 1989 Determination Order 17 percent unscheduled permanent disability award. (The award was later reduced to 3 percent pursuant to a December 1990 referee order.)

Before the October 1990 injury claim, claimant had been receiving treatment for neck and right arm complaints. Following the October 1990 injury, some of Dr. Hartmann's chart notes leading to the April 1991 time loss authorization (as well as a consulting report from Dr. Lewis) refer to claimant's February 1989 fall in addition to the October 1990 injury. Moreover, in response to an inquiry from the insurer, Dr. Hartmann lists the date of injury as November 1988. In light of such circumstances, we do not consider the insurer's failure to interpret Dr. Hartmann's 15-day time loss authorization as a reclassification request for the October 1990 injury claim to have been unreasonable. Rather, we conclude that the insurer had a legitimate doubt as to its obligations. Consequently, assuming that such an issue was properly before us, we would decline claimant's request to award an attorney fee under ORS 656.382(1).

Finally, claimant objects to the Referee's decision not to award an additional 5 days of temporary disability beyond the 10 days previously paid by the insurer. Specifically, claimant contends that the additional 5 days coincides with her 15 days of missed work and Dr. Hartmann's time loss authorization. In addressing this issue, we wish to emphasize that, since the claim was not closed, our decision is confined to claimant's procedural, as opposed to substantive, entitlement to temporary disability. See Galvin C. Yoakum, 44 Van Natta 2403 (1992) on recon 44 Van Natta 2492 (1992); Esther C. Albertson, 44 Van Natta 521, 522-23 (1992).

On April 4, 1991, Dr. Hartmann released claimant for 15 days. (Ex. 41-2). Recommending neck and shoulder exercises, Hartmann instructed claimant to return for a reexamination in 15 days. Claimant returned to her regular work duties on April 23, 1991. (Tr. 18). She received a check from the insurer for the period April 4 - April 17. (Tr. 16). On April 26, 1991, Dr. Hartmann subsequently

confirmed claimant's 15-day release from work. (Ex. 46). Noting that claimant was performing "entirely sedentary" work, Hartmann did not recommend a change in her occupation as a security guard.

Our review of the aforementioned circumstances leads us to the following conclusions. Dr. Hartmann's April 4, 1991 time loss authorization triggered the insurer's duty to provide temporary disability. Once such payments were initiated, the insurer could not terminate these benefits until the occurrence of one of the events enumerated in ORS 656.268(3). Here, the applicable event was claimant's April 23, 1991 return to her regular work duties. See ORS 656.268(3)(a). Therefore, notwithstanding Dr. Hartmann's "15-day" authorization, the insurer could not unilaterally terminate claimant's benefits until April 23, 1991 when she returned to regular work.

Accordingly, claimant is entitled to temporary disability under her October 1990 claim from April 4, 1991 until April 22, 1991 (the day before claimant's return to work). The insurer is directed to pay any additional temporary disability created by this order to claimant, less an attorney fee equal to 25 percent of the increase not to exceed $3,800.

ORDER

The Referee's order dated April 27, 1992 is affirmed in part and modified in part. The insurer is directed to notify the Director of claimant's reclassification request pursuant to ORS 656.277(1). Claimant is awarded temporary disability under the October 1990 claim payable from April 4, 1991 through April 22, 1991. This award may be offset by the temporary disability previously paid by the insurer for that period. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order, the total fee not to exceed $3,800. The remainder of the Referee's order is affirmed.

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March 10, 1993 Cite as 45 Van Natta 435 (1993)

In the Matter of the Compensation of
**ROBERT E. WOLFORD, Claimant**
WCB Case No. 91-06988
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The insurer requests review of Referee Nichols' order which: (1) reclassified claimant's occupational disease claim for isocyanate sensitivity from nondisabling to disabling; (2) found that the aggravation issue was moot; and (3) assessed a penalty and attorney fee for the insurer's allegedly unreasonable claims processing. On review, the issues are reclassification, aggravation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

On May 5, 1989, claimant filed an occupational disease claim, alleging an allergic reaction to isocyanate as a result of exposure to the chemical in January or February 1987. The 801 Form noted that there had been no time loss and and that the insurer had placed the claim in deferred nondisabling status.

A Form 1502, which was issued four days after the April 19, 1990 Stipulation was approved, accepted the claim as nondisabling.

CONCLUSIONS OF LAW AND OPINION

Supplemental Authorities

After the briefs were filed, the insurer submitted a supplemental memorandum of authorities. Supplemental briefs are generally not allowed; however, parties may submit supplemental authorities advising of recent changes in the law relevant to the issues at hand. Betty L. Juneau, 38 Van Natta 553

(1986). Unless otherwise authorized by the Board, no additional argument is permitted. OAR 438-11-020(2); Betty L. Juneau, supra.

Here, the insurer cites Steven V. Bischof, 44 Van Natta 255 (1992), which it contends is relevant to the issue of jurisdiction. On reconsideration and subsequent to the insurer's submission, we decided Bischof on a different basis than that for which the parties argue it here. See Steven V. Bischof, 44 Van Natta 433, aff'd mem 115 Or App 758 (1992). Consequently, Bischof is not relevant to the issues at hand.

Reclassification

The Referee concluded that the Hearings Division had jurisdiction to determine the disabling status of claimant's claim. We agree, but offer the following reasoning.

At the outset, it is necessary to determine claimant's "date of injury" for classification purposes. Claimant's first exposure to isocyanates occurred in January 1987. Claimant filed his claim on May 5, 1989. The insurer did not initially accept the claim, but placed it in deferred status. In October 1989, the insurer denied claimant's claim. By stipulation dated April 19, 1990, the insurer rescinded its denial. On April 23, 1990, the insurer formally accepted claimant's claim.

We have previously held that ORS 656.273(4)(b) applies only to accepted injuries or occupational disease claims. See Thomas L. Runft, 43 Van Natta 69 (1991). Therefore, the "date of injury" for classification purposes is the date that the insurer accepted claimant's occupational disease claim, i.e., April 23, 1990. Id. Having established claimant's date of injury, we now turn to the jurisdictional question.

ORS 656.277(2) provides:

> "A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation."

We have interpreted this provision to require claimant to seek reclassification of a nondisabling injury from the Evaluation Section prior to requesting a hearing on that issue. See Gregory S. Myers, 44 Van Natta 1759 (1992). In addition, we have held that under ORS 656.277(3)(c), the Board does not have jurisdiction to determine the disabling status of a claim until a worker exhausts the administrative remedies provided for in that provision. See Randy G. Fisher, 42 Van Natta 635 (1990). Finally, the Court of Appeals has recently discussed ORS 656.277 in DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993).

In DeGrauw, supra, the court noted that under ORS 656.277, a claim may be reclassified within one year of the date of injury. Further, the court found no statutory authority that specifically prohibited a carrier from reclassifying a claim from disabling to nondisabling more than one year from the date of injury. However, relying on the statutory scheme as contemplated by ORS 656.262(6) and ORS 656.268, the court held that a carrier may not reclassify a claim if more than one year has passed since the date of injury. The court reasoned that to hold otherwise would preclude a worker, through no fault of his or her own, from challenging a carrier's decision to reclassify a claim.

In the instant case, claimant requested reclassification from the Evaluation Section on April 9, 1991. This request was made within one year of his April 23, 1990 "date of injury" (the acceptance of his occupational disease claim). Nonetheless, in a letter dated May 17, 1991, the Evaluation Section informed claimant it lacked jurisdiction because the request was filed more than one year after the date of injury. The Evaluation Section used January 30, 1987 (the date of claimant's first exposure to isocyanate) as the date of injury.

However, for the reasons discussed above, for classification purposes, the date of injury is the date of claim acceptance by the insurer. In this regard, we note that our decision in Thomas L. Runft, supra is consistent with the reasoning expressed by the court in DeGrauw. That is, if "date of injury" was interpreted literally, claimant would not be able to challenge the nondisabling classification even if

he immediately objected to the classification. Like the court in Degrauw, we find that such an interpretation would not be consistent with the statutory scheme contemplated by ORS 656.262(6) and ORS 656.268. Therefore, we conclude that the Evaluation Section did have original jurisdiction to decide claimant's request.

Although the Evaluation Section denied claimant's request for reclassification on the basis that it lacked jurisdiction, its decision also constitutes an order denying a request for reclassification on the merits. See Karen S. McKillop, 44 Van Natta 2473 (1992). Inasmuch as claimant obtained an order from the Department prior to requesting a hearing, he exhausted his administrative remedies under ORS 656.277(3)(b). Accordingly, the Referee had jurisdiction over this matter.

Turning to the merits, we agree with and adopt the Referee's conclusions and reasoning finding that claimant's occupational disease claim was disabling with the following supplementation.

Subsequent to the Referee's order, the court issued its decision in SM Motor Co. v. Mather, 117 Or App 176 (1992). In Mather, the court held that "nondisabling status" as used in ORS 656.273(4)(b) is defined as an injury that requires medical services only. Id. at 180. Here, the Referee found and we agree that claimant's compensable occupational disease has rendered claimant temporarily disabled and will most likely result in an award of permanent disability. Accordingly, claimant's occupational disease requires more than medical services.

Because we have affirmed the Referee concerning the reclassification, we also agree that the aggravation issue is moot.

Penalties and Attorney Fees

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

Attorney Fees/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 is $1,000, 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 and statement of services), 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 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 September 20, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
**TODD M. BRODIGAN, Claimant**
WCB Case No. 91-12483
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of those portions of Referee Galton's order that: (1) increased claimant's unscheduled permanent disability award for an integumentary condition from 41 percent (131.2 degrees), as awarded by Order on Reconsideration, to 50 percent (160 degrees); (2) increased claimant's scheduled permanent disability for loss of use or function of his right leg from 5 percent (6.75 degrees), as awarded by Order on Reconsideration, to 66 percent (99 degrees); and (3) directed the employer to pay claimant's award of scheduled permanent disability at a rate of $305 per degree. On review, the issues are jurisdiction, extent of scheduled and unscheduled permanent disability, 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" with the following exception. We do not adopt the Referee's "Ultimate Findings of Fact."

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Matters

Claimant requested reconsideration of the Determination Order on the basis that he did not agree with the impairment findings used in that order. Contrary to ORS 656.268(7), the Order on Reconsideration was issued without the appointment of a medical arbiter. However, at hearing, claimant expressly waived the appointment of a medical arbiter.

We have held that if a party whom the mandatory "medical arbiter appointment" provision is intended to protect waives that mandatory procedure, the Order on Reconsideration is valid for review. See Brenton R. Kusch, 44 Van Natta 2222 (1992). Therefore, we find the Order on Reconsideration valid for review. Brenton R. Kusch, supra.

In addition, claimant requests that we abate our order and hold this matter in abeyance pending the final resolution of SAIF v. Herron, supra. For the reasons expressed in John B. Gordon, 44 Van Natta 1601 (1992), we deny claimant's request. In any event, we note that the Supreme Court has denied review in Herron. SAIF v. Herron, 315 Or 271 (1992).

### Jurisdiction

The employer did not seek reconsideration of the 41 percent unscheduled permanent disability award granted by the Determination Order. When an Order on Reconsideration affirmed that award, the employer requested a hearing. The Referee concluded that the employer was precluded from seeking elimination or reduction of the award because it had not sought reconsideration of the Determination Order. Thus, the Referee dismissed the employer's cross-request as untimely. We agree with the Referee's ultimate conclusion, but base our decision on the following reasoning.

ORS 656.268, in pertinent part, provides:

> "(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 within 180 days after copies of the notice of closure or the determination order are mailed, whichever is applicable." (Emphasis supplied).

Here, the Determination Order issued on February 12, 1991. Claimant requested reconsideration of the order pursuant to ORS 656.268(5). The Department received claimant's request for reconsideration on April 29, 1991. The Order on Reconsideration issued on August 30, 1991, affirming the Determination Order. Claimant requested a hearing objecting to the Order on Reconsideration. Claimant's hearing request was timely filed on September 6, 1991, the 74th day after the Determination Order was mailed. See Steve Werner, 44 Van Natta 2467 (1992). The employer filed a cross-request for hearing on November 15, 1991, 153 days after the Determination Order was mailed. See Steve Werner, supra.

In light of such circumstances, we reach the following conclusions. Claimant was the only party who sought reconsideration of the Determination Order. Although the employer requested a hearing within the requisite 180-day period from the Determination Order, it neglected to first seek reconsideration of that order as mandated by ORS 656.268(5). Consequently, we hold that the employer is prohibited from contesting claimant's permanent disability award.

We consider such a conclusion to be consistent with the statutory scheme in ORS 656.268 to provide a dispute resolution system which would determine disability ratings at the evaluation section level, thereby reducing the need to proceed to a hearing. We find this principle to be particularly applicable in this case, where the Order on Reconsideration affirmed the Determination Order award.

Although the issue is not presently before us, we can envision a qualification to the principle enunciated above. That exception is as follows. Assume that a party seeks reconsideration of a Determination Order and an award is changed in a manner consistent with that party's request; i.e., the claimant requested reconsideration and received an increased award or the carrier requested reconsideration and the award was decreased. In such a situation, the party who did not request reconsideration could request a hearing to contest that portion of the award altered by the Order on Reconsideration. However, that party could not seek a modification beyond the award granted by the Determination Order, which that party had previously chosen not to dispute.

Accordingly, we hold that, because the employer neglected to first seek reconsideration of the Determination Order (and since the Order on Reconsideration did not disturb the Determination Order award), the employer is precluded from seeking elimination or reduction of claimant's permanent disability award.

Extent of Permanent Disability

The Referee found that the temporary standards which were in effect on the date of the Notice of closure were invalid. The Referee, therefore, applied the previous permanent standards to rate the extent of claimant's disability. Subsequent to the Referee's order, we recently held that neither a referee nor the Board has authority to declare the aforementioned temporary rules invalid. Eileen N. Ferguson, 44 Van Natta 1811 (1992). Accordingly, in conducting our "de novo" review, we apply the standards in effect on the date of closure.

Former OAR 436-35-270 through 436-35-440, as amended by temporary rules in effect at the time of the February 12, 1991 Determination Order, apply to the rating of claimant's permanent disability. WCD Admin. Orders 6-1988, 15-1990 and 20-1990.

Extent of Unscheduled Permanent Disability

The Referee increased claimant's unscheduled permanent disability award for an integumentary condition from 41 percent to 50 percent. The employer contends that claimant is not entitled to unscheduled benefits under former OAR 436-35-440 for skin disorders and impairments of the integumentary system. For the reasons previously discussed, the employer can only contest the 9 percent increase granted by the Referee's order.

The Order on Reconsideration affirmed the Determination Order award of 41 percent for a Class III skin or integumentary impairment. OAR 436-35-440(2) provides that a Class III integumentary impairment rating is appropriate where:

"Signs and symptoms of skin disorder are present; AND

"Continuous treatment is required; AND

"There is moderate limitation in the performance of many work related activities."

Dr. Parshley, claimant's treating physician, opined that rating claimant's integumentary impairment is "impossible." Nevertheless, noting that claimant is limited in performing activities that require standing still, Dr. Parshley reported that "continuous treatment is not required -- or any treatment." (Ex. 71-29) (Emphasis in original).

Since continuous treatment is not required, we do not find that claimant has established a Class III integumentary impairment. OAR 436-35-440(2). Thus, her impairment is either classified under Class II (intermittent treatment and mild limitation of work activities) or Class I (with treatment no or minimal limitation). The impairment value for Class II is 15 percent, while the value for Class I is 3 percent. We need not resolve this impairment classification issue because, regardless of the classification, claimant's unscheduled permanent disability award would not exceed the 41 percent previously granted by the Determination Order and affirmed by the Order on Reconsideration. Inasmuch as the employer is precluded from contesting that award, we hold that claimant is entitled to 41 percent unscheduled permanent disability.

Accordingly, we reverse the Referee's additional award of 9 percent unscheduled permanent disability for an integumentary condition. The Determination Order award of 41 percent unscheduled permanent disability, as affirmed by the Order on Reconsideration, is reinstated and affirmed.

Extent of Scheduled Permanent Disability

The Determination Order awarded 5 percent scheduled permanent disability for loss of use or function of the right foot. An Order on Reconsideration affirmed that award. The Referee increased claimant's award to 66 percent for the right leg.

As previously explained, the employer may challenge the Referee's increased award. Contesting that award, the employer argues that there is no evidence relating the range of motion losses provided in Dr. Parshley's April 1991 report to the August 1987 compensable injury. We agree.

Claimant has a preexisting "club foot" condition which has required multiple surgeries prior to his compensable injury. (Ex. 73). Under such circumstances, we conclude that the issue of whether claimant's permanent impairment is causally related to his compensable injury is a complex medical question. The resolution of this issue largely turns on the 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). Furthermore, any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings. See ORS 656.283(7); 656.295(5); 656.726(3)(f)(B); William K. Nesvold, 43 Van Natta 2767 (1991).

There is no medical evidence that specifically relates claimant's range of motion losses to the August 1987 injury. Rather, Dr. Parshley opines that: "It is impossible for me to assess how much change in range of motion in the right ankle is a result of the current injury and how much was preexisting from his 'club foot' and its subsequent surgeries. Some loss of range of motion would be reasonable but whether this is real or not is unclear." (Ex. 67). In regard to claimant's right foot and toes, Dr. Parshley makes no specific findings in regards to what portion of losses, if any, are attributable to his compensable injury. Accordingly, we decline to assign any values for loss of range of motion based on those findings. See OAR 436-35-007(2); John R. Johanson, 44 Van Natta 1511 (1992).

Finally, the Referee assigned a value of 50 percent for a dermatological condition with loss of activities pursuant to former OAR 436-35-230(7). However, there is no medical evidence relating a dermatological condition with a limitation of function to his compensable injury. Rather, Dr. Parshley found that claimant's "skin rubs raw occasional from shoes." (Ex. 71-8). Dr. Parshley made no specific findings attributing claimant's skin rash to his compensable injury. Nor did Dr. Parshley make specific findings that the occasional rash limited function in regard to claimant's right foot or right leg.

The employer does not contest the sensory change findings and impairment. Furthermore, on the basis of Dr. Parshley's opinion that claimant sustained decreased pinprick and light touch sensation in the grafted area on his foot due to his compensable injury (Exs. 67; 71), we find no reason to disturb the 5 percent award for sensory change. Accordingly, we affirm that portion of the Determination Order which awarded claimant 5 percent scheduled impairment to his right foot due to loss of plantar sensation. Former OAR 436-35-200(1).

Claimant argues that he is entitled to a scheduled award for chronic condition limiting repetitive use. We disagree.

Under the standards in effect at the time of claimant's claim closure, claimant is not entitled to a value for chronic condition as the impairment in his right foot exceeds 5 percent. See former OAR 436-35-010(8)(a).

Accordingly, we reverse the Referee's increased scheduled permanent disability award. The Determination Order award of 5 percent scheduled permanent disability for the right foot, as affirmed by the Order on Reconsideration, is reinstated and affirmed.

Rate of Scheduled Disability

Subsequent to the Referee's order, the court held that the rate of scheduled permanent disability awards shall be paid at the rate existing at the time of the compensable injury. SAIF v. Herron, supra. Consequently, we reverse that portion of the Referee's order which directed the employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant's scheduled permanent disability award shall be paid at the rate existing at the time of his 1987 compensable injury (apparently $125 per degree).

ORDER

The Referee's order dated December 30, 1991 is affirmed in part and reversed in part. The Referee's 9 percent (28.8 degrees) unscheduled permanent disability award for an integumentary condition is reversed. The Determination Order award of 41 percent (131.2 degrees), as affirmed by the Order on Reconsideration, is reinstated and affirmed. The Referee's 66 percent (99 degrees) scheduled permanent disability award for the right leg is reversed. The Determination Order award of 5 percent (6.75 degrees) scheduled permanent disability is reinstated and affirmed. Claimant's scheduled permanent disability award shall be paid at the rate in existence at the time of his 1987 compensable injury. The Referee's "out-of-compensation" attorney fee awards are reversed. The remainder of the Referee's order is affirmed.

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March 11, 1993 Cite as 45 Van Natta 441 (1993)

In the Matter of the Compensation of
**INEZ M. HORSEY, Claimant**
WCB Case No. 91-11026
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of those portions of Referee Black's order which: (1) awarded temporary partial disability based on a 46-week period; and (2) declined to award an insurer-paid attorney fee for claimant's counsel's efforts in obtaining increased compensation. On review, claimant contends that the Referee miscalculated claimant's temporary disability and that she is entitled to an insurer-paid attorney fee for prevailing against a "denial" of temporary disability.

On March 4, 1993, we approved a claim disposition agreement (CDA), in which claimant released her rights to workers' compensation benefits (including temporary disability), except medical

services, for her compensable injury. WCB Case No. C3-00275. Inasmuch as one of the issues on review pertains to claimant's entitlement to temporary disability and since she has released her rights to such benefits pursuant to the approved CDA, we conclude that the temporary disability issue has been resolved. Furthermore, for the reasons expressed in Gloria J. Shelton, 44 Van Natta 2232 (1992), Charles E. Martin, 43 Van Natta 1522 (1991), Robert Barnes, 41 Van Natta 97 (1989), and Charles L. Smith, 41 Van Natta 75 (1989), claimant is not entitled to an insurer-paid attorney fee for her counsel's efforts regarding the temporary disability issue.

Accordingly, as supplemented and modified herein, we affirm and adopt the Referee's order dated June 24, 1992, as reconsidered August 13, 1992.

IT IS SO ORDERED.

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March 11, 1993 Cite as 45 Van Natta 442 (1993)

In the Matter of the Compensation of
**FLOYD D. MAUGH, Claimant**
WCB Case No. 91-09261
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Nichols' order that upheld the self-insured employer's denial of his occupational disease claim for his bilateral knee condition. On review, the issue is compensability.

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

On review, claimant argues that the Referee's analysis of this matter conflicts with the Court of Appeals' decision in Kepford v. Weyerhaeuser Co., 77 Or App 363 (1986). Claimant overlooks a crucial distinction between this matter and Kepford. In Kepford, the claimant sought compensation for a degenerative condition which preexisted his compensable injury and his subsequent work exposures. Relying on well-established case law to the effect that aggravation of a preexisting disease may be a separate compensable condition, the court concluded that the claimant could establish compensability by proving that his job exposures, along with the compensable injury, were the major causes of a worsening of his preexisting disc disease. Id. at 365, citing Wheeler v. Boise Cascade, 298 Or 452 (1985).

Here, by contrast, claimant is not seeking to establish compensability of a condition which preexisted his compensable injuries. Rather, claimant is seeking compensation for conditions which have evolved out of his compensable injuries and subsequent work and off-work exposures. The issue is whether claimant is limited to the benefits available on his prior accepted claims under the Board's own motion authority or, instead, whether claimant is entitled to all of the benefits which flow from establishing a "new" occupational disease. Kepford is not controlling on this issue. Further, we agree with the Referee that, in order to establish a "new" occupational disease, claimant must prove that his work exposures subsequent to his compensable injuries are the major contributing cause of his condition. Moreover, we agree that claimant has failed to sustain this burden.

ORDER

The Referee's order dated May 18, 1992 is affirmed.

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In the Matter of the Compensation of
**RANDY E. McTIMMONDS, Claimant**
WCB Case No. 91-15063
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Crumme's order that upheld the SAIF Corporation's denial of his claim for injuries sustained in a motor vehicle accident on the basis that he was not a subject worker. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was an independent contractor and therefore upheld the SAIF Corporation's denial. We disagree.

In 1989, the legislature enacted a statutory formula for determining whether workers are employees or independent contractors. In accordance with ORS 656.005(29), "independent contractor' has the meaning for that term as provided in ORS 670.600 (former ORS 701.025). See also OAR 436-50-030. The statute provides that, as used in ORS Chapter 656, an individual or business entity that performs labor or services for remuneration shall be considered to perform the labor or services as an independent contractor if the enumerated standards are met. ORS 656.700(1)-(8). We have interpreted ORS 656.700 to provide that, in order for a party to be considered an independent contractor, all eight of the provision of ORS 656.700 must be met. Gregory L. Potts, 43 Van Natta 1347 (1991).

ORS 656.600(3) provides that an individual will be considered an independent contractor if the individual "furnishes the tools or equipment necessary for the performance of the contracted labor or services." In the present case, the tow truck was equipment necessary (indeed, the most necessary) to the performance of claimant's job. Although under the agreement claimant "leased" the tow truck, he leased it from PAC (the alleged employer). The tow truck was marked with PAC's business name, not claimant's. More importantly, claimant was not allowed to take the tow truck to his residence. Rather, when claimant was not using it, it stayed on PAC's premises and was used by other tow truck drivers. Under these circumstances, we conclude that claimant did not furnish the equipment necessary for his job. Therefore, ORS 656.600(3) has not been met.

In addition, although claimant had the authority, under the agreement, to hire other persons, all hirings had to be preapproved by PAC. Therefore, we also conclude that ORS 656.600(4) has not been met. Finally, all administrative services as functions for claimant's "business" were provided by PAC. Moreover, all advertising, including telephoning listings, were done under PAC's name, not claimant's. See ORS 670.600(8).

Inasmuch as at least one of the conditions provided in ORS 670.600 has not been met in this case, claimant is not an "independent contractor." Gregory L. Potts, supra; Mark Walton, 44 Van Natta 2239 (1992). Consequently, we conclude that claimant is a subject worker. Accordingly, we will set aside SAIF's denial.

Claimant is entitled to an assessed attorney fee for prevailing against SAIF'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 assessed attorney fee for claimant's counsel's services at hearing and on review is $4,500, 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 appellate briefs, 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 June 4, 1992 is reversed in part and affirmed in part. That portion which upheld the SAIF Corporation's denial is reversed. The denial is set aside and the claim is remanded to the SAIF Corporation for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $4,500, payable by the SAIF Corporation. The remainder of the order is affirmed.

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March 11, 1993 Cite as 45 Van Natta 444 (1993)

In the Matter of the Compensation of
**KIMBERLY M. SAYLOR, Claimant**
WCB Case No. 91-14284
ORDER OF ABATEMENT
Francesconi & Busch, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

On February 25, 1993, we affirmed a Referee's order which had set aside the SAIF Corporation's lumbosacral strain injury claim. Submitting a December 1992 referee-approved Disputed Claim Settlement, SAIF contends that the compensability issue in this case has been settled.

In light of such circumstances, we withdraw our February 25, 1993 order. Claimant is requested to file her response to SAIF's motion. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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March 11, 1993 Cite as 45 Van Natta 444 (1993)

In the Matter of the Compensation of
**GLORIA J. SCRIVEN, Claimant**
WCB Case Nos. 91-08719 & 91-07641
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Neal's order that: (1) set aside its denial of claimant's aggravation claim for a worsened low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's new injury claim for the same condition. In her brief, claimant renews her request for a penalty based on SAIF's allegedly unreasonable compensability denial. On review, the issues are responsibility and penalties. We affirm on the responsibility issue and assess a penalty.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

SAIF's June 12, 1991 denial of compensability was unreasonable.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's order, with the following supplementation.

Whether claimant suffered an aggravation or a new injury is a question of fact. Delta/McLean Trucking v. Wyncoop, 106 Or App 319, 323 (1991)(citing Boise Cascade v. Starbuck, 296 Or 238, 244-45 (1984)). Here, based on the record as a whole, (see e.g., Exs. 45b, 50), we agree with the Referee that claimant suffered a continuation of her 1988 injury (which had never completely resolved) in 1991 rather than a new injury. See Taylor v. Mult. School District, 109 Or App 499 (1991); Gerald K. Mael, 44 Van Natta 1481 (1992).

The Referee declined to award a penalty against SAIF for its allegedly unreasonable denial. In reaching this conclusion, the Referee found that SAIF had a legitimate doubt concerning compensability, based on the Orthopaedic Consultants' June 3, 1991 report. (See Ex. 47). We disagree.

Although the Consultants opined that there was no objective evidence that claimant's 1988 injury-related condition worsened, they also stated that claimant's 1991 problems were "felt to be a new incident superimposed on [claimant's] previous injury [and that claimant's condition] has resolved to her previous condition that was present prior to the January 15, 1991 incident." (Id). In our view, neither this opinion nor any other evidence in the record provided a legitimate basis to doubt compensability of claimant's back condition. Under these circumstances, we find that SAIF's denial, (Ex. 48), was unreasonable. See SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983) (Where the only evidence concerning causation indicates that the condition is compensable, denial of compensability is not reasonable); see also Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

In addition, because SAIF's denial of compensability prevented issuance of a ".307" order, its conduct resulted in delay in payment of benefits for claimant's compensable condition. Accordingly, a penalty against SAIF is appropriate. ORS 656.262(10); SAIF v. Moyer, supra; Steven R. Holmes, 45 Van Natta 330 (February 25, 1993); Harold R. Borron, 44 Van Natta 1579 (1992)(A penalty may be assessed when an unreasonable denial of compensability delays payment of compensation by preventing designation of a paying agent). Accordingly, we assess a penalty of 25 percent of "amounts then due" at hearing. See ORS 656.262(10); Harold R. Borron, supra. This penalty shall be equally divided between claimant and her attorney.

In addition, because claimant's right to compensation was at issue and thus at risk at hearing, claimant is entitled to a carrier-paid fee for services rendered on review pursuant to ORS 656.382(2). See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992).

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 $300, 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) and the complexity of the issue.

## ORDER

The Referee's order dated December 27, 1991, as amended June 3, 1992, is modified in part and affirmed in part. Claimant is awarded a penalty of 25 percent of all compensation due at the time of hearing, to be paid in equal shares to claimant and her attorney. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $300, payable by SAIF.

In the Matter of the Compensation of
**MICHAEL L. WHITNEY, Claimant**
WCB Case Nos. 92-00485 & 92-00484
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Brazeau's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld EBI Companies' denial of claimant's aggravation claim for the same condition; and (3) assessed a penalty against SAIF for an unreasonable denial of compensability of the low back condition. On review, the issues are responsibility, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that EBI had carried its burden to prove that claimant had sustained a new compensable injury at SAIF's insured. Consequently, the Referee found that responsibility for claimant's back condition shifted to SAIF.

On review, SAIF contends that claimant's back condition in December 1991 was an aggravation of his 1989 injury at EBI's insured rather than a new injury. We agree.

In order to avoid responsibility under ORS 656.308(1), EBI, as the last insurer against which claimant had a compensable low back injury, must establish that claimant sustained a new compensable injury involving the same condition while working for SAIF's insured. Ricardo Vasquez, 43 Van Natta 1678 (1991).

In June 1989, claimant was compensably injured at EBI's insured when his cork boots got caught in his chaps and he fell in a hole suffering a twisting injury to his back. Since that injury, claimant has suffered from periodic flare-ups of his back condition. Claimant testified that the back problems stemming from the 1989 injury have never resolved. At the time he went to work for SAIF's insured in early 1991, claimant's back condition was symptomatic. Claimant testified that he noticed his back aching more a few days before it went out in December 1991 and felt that he could sometimes predict when his back was going to go out. On December 3, 1991, while working at SAIF's insured, claimant bent over to pick up a guy line and experienced a sharp pain in the lumbar spine. Claimant's treating physician, Dr. Panum, a specialist in occupational medicine, opined that claimant's back condition in December 1991 was most likely an aggravation of the underlying 1989 injury. Dr. Panum stated:

> "The thing that I have to go on is his relating to me in the history that his symptoms - - his current symptoms, '91, are very much the same as they had been in previous episodes preceding that. That's really the best information that I have so that it - - it suggests to me that it's an ongoing thing related back."

The only new symptom claimant may have had after the December 1991 exacerbation is pain radiating into his leg. However, the record is unclear as to whether or not claimant had radiating pain prior to the December 1991 incident.

Finally, Dr. Fry, orthopedist, and Dr. Barth, neurologist, saw claimant in an independent medical examination (IME). They also attributed claimant's back condition to the June 1989 injury at EBI's insured.

Based on the record as a whole, we conclude that claimant did not sustain a new injury when he merely bent over at SAIF's insured, but rather suffered a continuation of his 1989 injury which had never completely resolved. See Taylor v. Mult. School District, 109 Or App 499 (1991); Gerald K. Mael, 44 Van Natta 1481 (1992).

Our decision in this case is consistent with the legislative goal behind ORS 656.308(1), which was to encourage employers to hire workers who have sustained previous compensable injuries. In enacting ORS 656.308(1), the legislature intended to make it more difficult for an employer with an accepted condition to shift responsibility to a later employer. The requirement that a worker sustain a new compensable injury in order for responsibility to shift was intended to reduce the likelihood that a new employer would become responsible for conditions which were actually caused by an injury at a prior employment. This was intended to encourage employers to hire injured workers. In Rodney H. Gabel, 43 Van Natta 2662 (1991), we quoted the following testimony of Representative Mannix concerning the purpose of ORS 656.308(1):

> "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.

Accordingly, we conclude, based upon the evidence, that claimant did not sustain a "new compensable injury" at SAIF's insured. Thus, responsibility for claimant's back condition remains with EBI.

Penalties and Attorney Fees

Both insurers denied compensability as well as responsibility. The Referee found that although each insurer had a legitimate doubt concerning its liability at the time the compensability denials were issued, as the claims progressed, all of the medical evidence indicated that claimant's back condition was compensable. The Referee found that because both insurers failed to retract their compensability denials at the point it became clear that claimant's condition was work-related, those denials became unreasonable. We agree with, and adopt the Referee's conclusion that both compensability denials became unreasonable.

For its unreasonable compensability denial, EBI is assessed a penalty equal to 25 percent of amounts then due, to be divided equally between claimant and his attorney. ORS 656.262(10).

Here, we find that SAIF's failure to retract its compensability denial, even after it became apparent that the claim was compensable as against one of the insurers, constituted unreasonable resistance to the payment of compensation. In this regard, SAIF's conduct, in combination with that of EBI, prevented a .307 order from issuing. This resulted in a delay in payment of benefits which were compensable. Accordingly, we conclude that a penalty is appropriate. ORS 656.262(10).

In Harold R. Borron, 44 Van Natta 1579 (1992), although we upheld the insurer's denial of responsibility for a knee condition, we found that the insurer had unreasonably denied compensability of that condition because there was no evidence that the condition was not work-related. Relying on Kim S. Jeffries, 44 Van Natta 419 (1992), we assessed a penalty against the nonresponsible carrier for this unreasonable compensability denial. We based the penalty on all compensation due from the responsible carrier at the time of the hearing, including medical services. Ben Santos, 44 Van Natta 2228, on recon 44 Van Natta 2385 (1992).

Furthermore, in a similar case, the Court of Appeals upheld assessment of a penalty against a nonresponsible carrier for its unreasonable denial of compensability. SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983). In Moyer, the court found that the nonresponsible carrier's denial of compensability was unreasonable because the only evidence regarding causation stated that the claimant had sustained a new work related injury. The court also found that this denial resulted in delay of payment of compensation by preventing the designation of a paying agent pursuant to ORS 656.307.

In addition, the court rejected the carrier's argument that, even if a penalty could be assessed under former ORS 656.262(9) [now ORS 656.262(10)], there were no "amounts then due" from it as the nonresponsible carrier. SAIF v. Moyer, supra at 503. The court reasoned that the carrier would have it add to the statute the words "from the insurer against whom the penalty is assessed" after the words "amounts then due." The court found that "[n]o authority exists for that construction, and it would defeat the purpose of penalties to encourage insurers to withhold benefits." Id.

We find that the same reasoning applies to the current version of the statute. Thus, we find that a penalty may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent. This penalty may be based on the "amounts then due" from the responsible carrier.

In reaching our decision, we distinguish the present case from Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). In Randall, an insurer denied an aggravation claim and that denial was subsequently upheld. The court held that no attorney fee pursuant to ORS 656.382(1) could be assessed because, inasmuch as the claim was not compensable, there was no unreasonable resistance to the payment of compensation. The present matter, by contrast, involves a responsibility determination, and although the claim is not compensable as to SAIF, SAIF's actions in denying compensability, in concert with the actions of EBI, prevented the issuance of a .307 order and delayed payment of benefits to claimant which were ultimately compensable. Accordingly, although the claim is not compensable as to SAIF, its actions in the context of this responsibility case, resulted in a delay in payment of benefits which were compensable.

In its brief, EBI relies on our decision in David M. Peterson, 44 Van Natta 386, 388 (1992), to support its argument that a penalty may not be assessed against a nonresponsible carrier. However, as we recently discussed in Michael P. Yauger, 45 Van Natta 419 (1993), Peterson is contrary to the Moyer holding, as well as the reasoning expressed in Borron.

Accordingly, for its unreasonable compensability denial, SAIF is assessed a penalty equal to 25 percent of amounts then due, to be divided equally between claimant and his attorney. ORS 656.262(10).

Attorney Fees/Board Review

Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992).

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 is $1,000, 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 and statement of services), the complexity of the issues, and the value of the interest involved.

## ORDER

The Referee's order dated July 9, 1992 is reversed. The SAIF Corporation's responsibility denial is reinstated and upheld. EBI's denial is set aside and the claim is remanded to EBI for processing according to law. The Referee's $2,500 assessed attorney fee award shall be paid by EBI. For EBI's unreasonable denial of compensability which prevented designation of a paying agent, claimant is awarded a penalty equal to 25 percent of all compensation owing at the time of the hearing, payable by EBI in equal shares to claimant and his attorney. For SAIF's unreasonable denial of compensability which prevented designation of a paying agent, claimant is awarded a penalty equal to 25 percent of all compensation owing at the time of the hearing, payable by SAIF in equal shares to claimant and his attorney. For services on Board review, claimant's attorney is awarded $1,000, payable by EBI.

In the Matter of the Compensation of
**RALPH L. WITT, Claimant**
WCB Case Nos. 90-22553, 90-22551, 91-00579, 90-22549, 90-22550, 90-22552, 91-00582, 91-00581, 91-05226, 91-05227, 91-08190, 90-03335, 91-08189 & 91-00580
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
Norm Cole (Saif), Defense Attorney
Snarskis, et al., Defense Attorneys
Kevin Mannix, P.C., Defense Attorneys
Terrall & Associates, Defense Attorneys
Craig Creel, Defense Attorney
Mitchell, et al., Defense Attorneys

On October 30, 1992, we abated our October 6, 1992 Order on Review which had: (1) reversed that portion of the Referee's order that set aside EBI's denial of claimant's claim for an asbestosis condition; (2) reversed that portion of the Referee's order that upheld Aetna's denial of the claimant's claim for the same condition; (3) reversed the Referee's award of an attorney fee under ORS 656.382(1); and (4) made the Referee's $1,000 attorney fee award payable by Aetna rather than EBI. On reconsideration, Aetna also requests that this matter be reviewed by the Board en banc. After further consideration of the matter, we issue the following order.

## FINDINGS OF FACT

Claimant was self-employed through his company, Bear Creek Electric. Claimant stopped working in May 1988 due to his lung condition.

In 1987, the responsibility for claimant's lung condition was litigated before Referee Mongrain. Along with other carriers, EBI and Aetna were parties to the proceeding; EBI provided coverage for claimant's company from October 1, 1980 through September 30, 1982 and Aetna provided coverage from October 1, 1986 through May 1988. The "Mongrain" hearing was limited to the issue of responsibility for claimant's "asbestos-related lung condition"; (at the beginning of the hearing, EBI's attorney conceded compensability "of claimant's condition.")(Ex. 67-1).

Referee Mongrain found that claimant had been exposed to asbestos during June, July and December 1976; February and June 1977; October 1977 through March 1978; August 1982 through January 1983; February 1984; March, April and May 1986; and July 1987. (Id. at 2). Referee Mongrain concluded that "claimant became disabled by his asbestos-related lung condition in 1984. At that point responsibility became fixed with EBI Companies[.]" (Id. at 3). The Referee set aside EBI's denial and remanded the claim for acceptance. The order subsequently was amended to include the Referee's finding that claimant proved that his "asbestos-related lung condition was not independently worsened by exposure subsequent" to EBI's period of coverage. (Ex. 68-1). Following a motion for reconsideration by EBI, the order and amendment were republished in their entireties. (Ex. 69A-1).

In 1989, Dr. Edwards, pulmonary and internal medicine specialist, diagnosed claimant with asbestosis and pleural fibrosis, both of which Edwards attributed to prior exposure to asbestos. (Ex. 84-2).

A January 1990 Determination Order awarded claimant 46 percent unscheduled permanent disability. (Ex. 120-1). In June 1990, EBI denied responsibility "for any condition diagnosed as asbestosis," stating that it was "in receipt of medical opinion that [claimant] sustained a distinct and separate occupational disease diagnosed as asbestosis" and that this condition "did not arise out of and in the course and scope" of claimant's employment. (Ex. 130-1).

## CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we deny Aetna's request for en banc review of this case. While the Board may sit en banc in rendering a decision, it may also sit in panels. See Or Laws 1991, ch 954 Sec. 3. When sitting in panels, a majority of the particular panel may issue the Board's decision. See id. Whether a case is reviewed en banc is a matter that the Board decides on its own motion. Such review may not be initiated by a party. Aetna's request for en banc review is denied. See Kurt D. Cutlip, 45 Van Natta 79 (1993) (on recon); Brenda K. Allen, 44 Van Natta 2476 (1992) (on recon).

Res Judicata

The Referee concluded that EBI was barred by claim preclusion from denying compensability and responsibility for claimant's asbestosis, finding that, under Referee Mongrain's order, EBI was liable for claimant's "asbestos-related lung condition" and that asbestosis came under such a definition. Alternatively, the Referee concluded that claimant's "asbestosis condition was disabling on June 20, 1984 when EBI was on the risk."

EBI challenges both conclusions. First, it asserts that it is not barred by claim preclusion from denying claimant's asbestosis condition. Specifically, EBI contends that the asbestosis condition had not been diagnosed at the time of the 1987 order and that the order addressed only claimant's pleural fibrosis condition. Therefore, EBI maintains the asbestosis condition has not been litigated and it is not precluded from denying the condition.

On our initial review of this case, we adopted EBI's position. On reconsideration of the matter, however, we conclude that res judicata does operate to bar EBI from relitigating compensability of and responsibility for claimant's asbestosis condition.

Res judicata is composed of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, however, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

The issue litigated to final judgment by the 1987 order was responsibility for claimant's "asbestos-related lung condition." (Ex. 67-1) Although, in summarizing the medical evidence presented in the 1987 case, the Referee's order issued in that case refers to "pleural fibrosis" or "fibrosis of the lining of the lung," elsewhere in the medical evidence presented at that time, claimant's condition was diagnosed as "pleural and pulmonary fibrosis secondary to asbestosis," "lung disease secondary to asbestosis," (See eg. Exs. 65, 63, 37), or simply "asbestosis." (See Exs. 16, 24).

The Referee's order in the 1987 case did not contain any findings as to what specific asbestos-related lung condition claimant had, for which EBI was responsible. Absent such findings, our initial Order on Review in the present case stated that the 1987 order "is most reasonably construed as being limited to claimant's pleural fibrosis condition". For that construction, we relied primarily on expert witness testimony given at the hearing in the present case, to the effect that pleural fibrosis and asbestosis are distinct processes that involve different areas of the lung, and that although claimant had asbestosis as early as 1984, his asbestosis was asymptomatic at that time. We also relied on the opinion of Dr. Edwards and Dr. Keppel that some physicians use the term "asbestosis" loosely, in reference to any asbestos-related lung disease, when technically speaking, it should only be used in reference to one aspect or process of asbestos-related lung disease. On further consideration of the matter, we believe our construction of the 1987 order, although perhaps reasonable, was nonetheless erroneous for purposes of res judicata.

The lack of a definitive diagnosis in 1987 did not defeat claimant's claim for compensation. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Lori A. Sosa, 43 Van Natta 1744 (1989). The fact that the diagnosis of claimant's asbestos-related lung condition had not been confirmed at the time of the litigation, cannot now be construed to bar his claim. Tripp v. Ridge Runner Timber Services, supra. Here, the medical evidence available in 1987 referred to both pleural fibrosis as well as asbestosis. Moreover, EBI did not seek, in the 1987 litigation, to limit the scope of its liability for claimant's asbestos-related lung disease to only pleural fibrosis. In addition, the 1987 Opinion and Order deciding compensability of and responsibility for claimant's asbestos-related lung condition, was not appealed to the Board and has become final. Under these circumstances, we conclude that the 1987 order must be taken "as is," as having addressed compensability of claimant's asbestos-related lung condition, which included asbestosis. Accordingly, we find that EBI is barred by issue preclusion from now raising the compensability issue.

We further find that EBI is barred from litigating compensability of and responsibility for claimant's asbestosis condition under the doctrine of claim preclusion. The "factual transaction" at issue in the 1987 action concerned responsibility for claimant's "asbestos related lung condition." That "transaction" finally determined that claimant's lung condition due to exposure to asbestos was compensable and that EBI was responsible for that condition. In the prior litigation, although asbestosis had been mentioned as a possible diagnosis for claimant's condition, and pleural fibrosis had been raised as a separate condition, EBI did not seek to limit the scope of its acceptance to only the pleural fibrosis condition. Thus, we find that compensability of the asbestosis could have been raised in the 1987 litigation. The "factual transaction" at issue in the current proceeding also concerns responsibility for claimant's disability from asbestosis. Accordingly, inasmuch as this issue could have been raised in the prior proceeding, we conclude that EBI is barred from litigating it now.

Furthermore, the medical evidence presented in the present case, if considered, does not require a contrary result. The evidence (from Dr. Keppel and Dr. Edwards) is undisputed that although claimant has two conditions (in that they damage different sites of the lung), they both have the same cause: inhalation of asbestos particles. According to Keppel and Edwards, it is difficult to separate the two asbestos-related conditions as though they were distinct entities in the lung. The two conditions produce the same symptoms: impaired lung capacity. Thus, although they are separate processes, they are not truly distinct diseases. (Ex. 171-36). One process takes place inside the lung; the other in the pleural lining of the lung. As Dr. Edwards said: "The sum total of his disability is a result of the sum of the two conditions and there is no way to say asbestosis did this much and pleural fibrosis did this much." (Ex. 169-29 to 30). In one report, Edwards did hazard an estimate. He said that of claimant's total restrictive lung impairment in 1989, 50 percent was due to pleural fibrosis and 50 percent was due to asbestosis. (Ex. 132-1). Keppel was only prepared to say the contribution of the asbestosis is "significant." (Ex. 129-2). Furthermore, neither physician was prepared to say that when the term "asbestosis" was used in the 1987 case by other physicians in reference to claimant's condition, that they were talking about pleural fibrosis rather than clinical asbestosis.

In conclusion, our decision makes practical sense, in that it will serve to avoid the confusion and disputes about claims processing that otherwise would likely occur if EBI had responsibility for one process affecting claimant's lungs and Aetna had responsibility for the other. As Edwards and Keppel explained, the two conditions produce the same symptoms, and are separate processes more than they are truly distinct diseases. As Edwards put it: "The sum total of his disability is a result of the sum of the two conditions and there is no way to say asbestosis did this much and pleural fibrosis did this much."

Finally, we find that EBI's denial of claimant's asbestosis condition was not unreasonable given the complexity of the medical issues and evidence and the perfunctory nature of the 1987 order. Therefore, we reverse the Referee's attorney fee award under ORS 656.382(1).

Inasmuch as EBI requested Board review and we have found that claimant's compensation should not be disallowed or reduced, claimant is entitled to an attorney fee award for services on review. See ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992). 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 is $750, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs), the complexity of the issues, and the value of the interest involved.

## ORDER

The Referee's order dated September 20, 1991 is reversed in part and affirmed in part. That portion of the order which awarded an attorney fee under ORS 656.382(1) is reversed. In all other particulars, the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by EBI.

In the Matter of the Compensation of
**KATHY M. ARCHER, Claimant**
WCB Case No. 91-04167
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Michael Johnson's order which found that she was precluded from litigating issues of reclassification and aggravation of her neck injury. On review, the issues are claim preclusion and, alternatively, reclassification and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claim preclusion

The Referee concluded that the doctrine of claim preclusion barred claimant from litigating the issues of reclassification and aggravation, as the issues were raisable at the time claimant entered into a July 11, 1990 stipulated settlement. We disagree.

Res judicata is comprised of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where its determination was essential to the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, on the other hand, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990).

Here, there was no actual litigation of either the reclassification or aggravation issues. Accordingly, issue preclusion does not apply. Therefore, we next consider whether claim preclusion is applicable in this case.

We conclude that the July 11, 1990 stipulation did not involve the same factual transaction that is at issue in the present case. The stipulation arose following the issuance of a Determination Order and denials of chiropractic treatment for claimant's back and neck. Whether claimant's claim was properly classified and whether claimant had sustained an aggravation are not necessarily based upon the same set of operative facts involved in issues of extent of disability and the frequency of chiropractic treatment. We, therefore, disagree with the Referee's conclusion that claim preclusion applies to bar litigation of the classification and aggravation issues.

Additionally, we do not agree that claimant has waived her right to proceed on the aforementioned issues by entering into a stipulation which provided that she waived all issues raised or raisable at the time of the stipulation. A waiver is the intentional relinquishment of a known right. Drews v. EBI Companies, supra. Here, we find no evidence that, at the time claimant entered into a stipulation with regard to denied chiropractic treatment, she intended to relinquish her right to request a hearing on the issues of classification and aggravation. Accordingly, we conclude that claimant has not waived her right to litigate those issues. See Chuck W. Chowning, 44 Van Natta 1591 (1992) (addressing similiar "raised or raisable" language in a stipulation).

Having concluded that claimant is not barred from litigating the issues of classification and aggravation, we proceed to address the merits of her claims.

Classification

At the time of claimant's injury, former ORS 656.262(12) provided that, if within one year after the injury, a worker claims that a nondisabling injury has become disabling, the insurer or self-insured

employer shall report the claim to the director immediately after receiving notice or knowledge of such claim. Similarly, current ORS 656.277(1) provides that, if within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268. Because claimant's request for hearing was filed after April 30, 1990, current ORS 656.277 applies to this matter rather than former ORS 656.262(12). See Precision Castparts Corp. v. Lewis, 115 Or App 732 (1992). However, the statutory changes between former ORS 656.262(12) and current ORS 656.277 do not affect our resolution of this case.

Here, we find that, within one year of her February 22, 1989 injury, SAIF received notice that claimant's injury had become disabling. Following the classification of her claim, Dr. Cummings sent two reports to SAIF indicating that claimant would have permanent impairment of the neck. On January 26, 1990, Dr. Cummings reiterated that claimant had permanent impairment of her neck, and he found that her left shoulder and cervical strain were not stationary. Dr. Cummings also reported that claimant was being taken off work. Finally, Dr. Cummings completed a form 829 relating to claimant's neck and left shoulder. SAIF received the form by early February 1991.

We conclude that Dr. Cummings' reports, which were received by SAIF within one year from the date of her injury, constitute a claim for reclassification. See ORS 656.005(6); Gregg Lewis, 43 Van Natta 1202, on recon 1326 (1991), aff'd Precision Castparts Corp. v. Lewis, supra. SAIF was obligated to report the claim to the Director. It did not do so. Accordingly, we remand this matter to SAIF to be reported to the Director for purposes of classification. See OAR 436-30-045 (no claim shall be reclassified unless the request or notice to an insurer that a nondisabling injury is disabling is made within one year of the date of injury).

Aggravation

Because we have above found that claimant's claim for reclassification was received by SAIF within the statutory one-year period, we do not treat this matter as an aggravation claim. Precision Castparts Corp. v. Lewis, supra 115 Or App at 735 ft nt 3.

ORDER

The Referee's order dated April 3, 1992 is reversed in part and affirmed in part. The neck claim (7719942K) is remanded to the SAIF Corporation for processing consistent with this order. 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 Referee's order is affirmed.

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March 12, 1993 Cite as 45 Van Natta 453 (1993)

In the Matter of the Compensation of
**DAN R. ARMSTRONG, Claimant**
WCB Case No. 91-12615
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lane, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Podnar's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a carpal tunnel condition; (2) upheld the insurer's partial denial of interim compensation; and (3) declined to award a penalty and related attorney fee for the insurer's allegedly unreasonable failure to pay interim compensation. On review, the issues are aggravation, interim compensation, and penalties and attorney fees. We reverse in part and affirm in part.

Claimant became medically stationary on May 14, 1991. His claim was closed by a May 22, 1991 Notice of Closure that awarded temporary total disability from October 23, 1990 through March 3, 1991 and March 19, 1991 through April 23, 1991.

Claimant received a written job offer to return to work. He requested medical leave and family leave, both of which were denied. The employer terminated claimant's employment as of April 24, 1991 because he did not return to work.

After his termination, but before his claim for aggravation, claimant worked on a lunch wagon for two days in June or July 1991. He also looked for other work. (Tr. 9 and 12). On September 1, 1991, he went to work part time driving a bus.

On July 25, 1991, claimant was examined by Dr. Melvin. Dr. Melvin wrote to the employer indicating that claimant had continuing bilateral carpal tunnel syndrome, with irritable median nerves, and positive compression and Phalen's tests. Dr. Melvin also stated that claimant's pain and numbness in both hands prevented him from working.

## FINDINGS OF ULTIMATE FACT

Since the last arrangement of compensation, claimant has sustained a symptomatic worsening resulting in diminished earning capacity. The worsened condition is established by medical evidence supported by objective findings.

Claimant was in the work force immediately prior to the aggravation of his compensable injury. Claimant was unable to work as a result of his aggravation.

The employer unreasonably denied payment of claimant's temporary disability compensation (interim compensation). This delay was a resistance to the payment of compensation.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

The Referee concluded that claimant had failed to establish by medical evidence supported by objective findings that his bilateral carpal tunnel condition had worsened. We disagree.

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(10 and (3).

Here, claimant was awarded no permanent disability compensation when his claim was closed on May 22, 1991. Claimant was examined by his treating physician, Dr. Melvin, hand specialist, on July 25, 1991. Dr. Melvin's report states:

> "I have examined [claimant] for evaluation of continuing pain and numbness of his hands.
>
> "As you know, [claimant] had bilateral carpal tunnel release surgery done by Dr[.] Nye in January 1991, and he has since been returned to work and his work related claim closed.
>
> "[Claimant's] problem is that the pain and numbness in both hands prevent him

"We, therefore, request reopening of his work-related claim, and permission to evaluate for further decompression surgery to his carpal tunnels."

This report indicates that claimant was experiencing pain and numbness in both hands, which was supported by objective evidence of irritable median nerves and positive compression and Phalen's tests. Because of this pain and numbness, claimant was unable to work. Dr. Melvin diagnosed a worsening of the compensable condition based on expert analysis of his examination findings and claimant's reported symptoms. Such evidence meets the definition of "objective findings." See Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991); Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991). The fact that earlier or later evaluations by competent physicians yielded different results, does not require us to conclude that Dr. Melvin's analysis is unreliable.

Claimant was also examined by Dr. Button, hand surgeon, on September 4, 1991. Claimant provided a history suggestive of recurrent carpal tunnel syndrome, but, because his clinical observations did not indicate such a recurrence, Dr. Button recommended that EMG and nerve conduction studies be repeated. He also suggested that claimant had functional features and that his rapid weight gain of 100 pounds in three months and possible fluid retention might affect the median nerves in the carpal tunnel region.

A November 1991 nerve conduction study revealed no abnormalities. (Ex. 28-17). Dr. Melvin did not find the nerve conduction studies to be dispositive and disagreed with the suggestion that claimant's rapid weight gain caused his current symptoms. Dr. Melvin continued to assert that claimant's condition had worsened, in that he experienced pain and numbness in both hands and that additional compression and Phalen's tests continued to be positive. The insurer asserts that the compression testing method employed by Dr. Melvin is not recognized in the medical community. However, no evidence was provided to establish that it is not a valid means of measurement recognized in the medical community.

When the medical evidence is divided, we give greater weight to the conclusion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 801, 814 (1983). Here, we find no reason not to give greater weight to the opinion of Dr. Melvin. Accordingly, we conclude that claimant has established at least a temporary worsening of his compensable condition by medical evidence supported by objective findings, which has resulted in diminished earning capacity. ORS 656.273(1) and (3); Smith v. SAIF, supra; Edward D. Lucas, supra. This is not a finding that claimant has proved a permanent worsening of his wrist condition. That issue is not yet ripe for determination.

Interim Compensation

The Referee concluded that claimant was not entitled to interim compensation because claimant had withdrawn from the work force. We disagree.

ORS 656.273(6) requires the employer to pay claimant 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. Doris A. Pace, 43 Van Natta 2526 (1991). Furthermore, to receive temporary total disability benefits, a claimant must be in the work force at the time of his disability. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant became disabled because of his compensable bilateral wrist condition on July 25, 1991, the day he sought treatment from Dr. Melvin, who stated that claimant could not work. The issue is whether claimant had voluntarily removed himself from the work force prior to July 25, 1991.

The record establishes that, although claimant was terminated by the employer on April 24, 1991 and he removed himself from the work force for a short time to care for his wife and new baby, he subsequently worked on a lunch wagon for two days in June or July and looked for other work prior to July 25, 1991. Claimant testified that he had not retired and had, in fact, begun working as a bus driver on September 1, 1991.

Under these circumstances, we find that at the time of his disability, claimant had not withdrawn from the work force. Accordingly, we conclude that claimant was entitled to interim compensation beginning 14 days after the insurer received medical verification of his inability to work.

Penalty and Attorney Fees

Claimant contends that the insurer's denial of interim compensation was an unreasonable refusal to pay compensation. We agree. We note that claimant withdrew the issue of an unreasonable denial of the aggravation claim at hearing. (Tr. 2).

ORS 656.262(10)(a) provides that if the insurer unreasonably delays or unreasonably refuses to pay compensation, the insurer shall be liable for an additional amount up to 25 percent of the amount then due. Here, the employer received Dr. Melvin's report on July 29, 1991. The insurer was on notice to begin interim compensation payments within 14 days of that date. ORS 656.273(6). Interim compensation is compensation due without regard for the compensability of the claim. It is designed to maintain the claimant during that period of disability when the insurer may investigate the question of compensability. Once a formal denial of the claim has issued, claimant is no longer entitled to interim compensation, but must prove the compensability of the claim. See Kim S. Jeffries, 44 Van Natta 824 (1992).

Instead of paying interim compensation, the insurer issued a partial denial of temporary disability compensation (interim compensation) on August 5, 1991. The insurer informed claimant that the reason for the denial was "information in your file indicates that you have voluntarily removed yourself from the work force." (Ex. 16). However, the record does not show that claimant removed himself from the work force entirely. At hearing, no evidence was offered by the insurer to indicate a reasonable basis for its determination that claimant had completely withdrawn from the work force as of July 25, 1991. Rather, the evidence reveals that claimant returned to the work force in June or July 1991, prior to the July 25, 1991 aggravation claim.

Given our analysis above, we conclude that the insurer's denial of interim compensation prior to issuing a formal denial of claimant's claim was an unreasonable resistance to the payment of compensation. Accordingly, we find that the insurer is liable for a penalty of 25 percent of the amounts due from July 25, 1991 until October 11, 1991, the date of the aggravation denial.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. 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 aggravation issue is $3,500, 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 appellate briefs, 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 April 7, 1992 is reversed in part and affirmed in part. The insurer's denials of claimant's aggravation claim and interim compensation are set aside and the aggravation claim is remanded to the insurer for processing according to law. Claimant is awarded temporary disability from July 25, 1991 through October 11, 1991. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly by the insurer to claimant's attorney. That portion of the order that declined to award a penalty pursuant to ORS 656.262(10) is reversed. Claimant is awarded a penalty of 25 percent of the temporary disability benefits due from July 25, 1991 to October 11, 1991. Claimant's attorney shall receive one-half of that penalty, in lieu of an attorney fee. The remainder of the order is affirmed. For services regarding the aggravation issue at hearing and on review, claimant's attorney is awarded an assessed attorney fee of $3,500, to be paid by the insurer.

In the Matter of the Compensation of
**MAXIMINO CARDENAS, Claimant**
WCB Case No. 91-09927
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of that portion of Referee Crumme's order which affirmed an August 5, 1991 Order on Reconsideration awarding 17 percent (25.5 degrees) scheduled permanent disability for the loss of use or function of his left knee. In his appellant's brief, claimant argues that his vascular condition is compensable and, therefore, should be considered in rating the extent of his disability. In its respondent's brief, the SAIF Corporation argues that the Referee erred in directing it to pay the remaining amounts due on claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are extent and rate of scheduled permanent disability. We affirm in part and reverse in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Extent of disability

Analyzing claimant's vascular condition as a consequential condition under ORS 656.005(7)(a)(A), the Referee concluded that claimant failed to establish that his compensable injury was the major contributing cause of the condition. The Referee, therefore, found claimant's vascular condition to be not compensable and declined to consider that condition in rating the extent of claimant's scheduled permanent partial disability. We agree and adopt the Referee's reasoning and conclusions in that regard.

The dissent asserts that by its conduct, SAIF "accepted" claimant's vascular condition. The dissent argues, therefore, that SAIF cannot now assert that claimant's vascular condition should not be considered in the rating of his extent of disability. Although the specific argument raised by the dissent was not presented by claimant on review, we address the argument for purposes of thoroughness.

The dissent bases its assertion on two grounds: (1) that SAIF's provision of medical care and payment of time loss after July 9, 1990, when claimant's venous insufficiency was identified, constituted an "acceptance" of the venous condition; and (2) that SAIF's Notice of Closure, which awarded 54 percent scheduled permanent partial disability for the left knee, constituted an "acceptance" of the venous condition by allegedly awarding permanent disability compensation for that condition, as well as for range of motion and left knee instability.

With regard to the dissent's first assertion, the dissent concedes that the mere payment of compensation for a condition does not constitute acceptance thereof or an admission of liability. See ORS 656.262(9). The dissent further asserts, however, that SAIF's payment of permanent partial disability compensation constituted an admission that claimant's venous condition was compensable, whereas the mere payment of temporary disability compensation may not have constituted such an admission.

First, it is unclear from this record whether or not SAIF, in fact, awarded permanent disability specifically for claimant's venous condition. Assuming that it did, however, we find Gloria T. Olson, 44 Van Natta 2519 (1992), to be instructive. In that case, the claimant asserted that the employer's failure to object to a Determination Order that awarded permanent disability for the residuals of a condition found not to be compensable constituted an "acceptance" of that condition. Citing ORS 656.262(9), we rejected the claimant's argument, holding that the employer's act of allowing an award of permanent disability to stand did not rise to the level of an "acceptance." Id. at 2521.

Olson is similar to the present case, in which SAIF arguably awarded permanent disability for claimant's venous condition. We conclude, however, that even if it did, its act of doing so did not constitute an "acceptance" of claimant's condition.

With regard to the dissent's second assertion, that SAIF's Notice of Closure constituted a "stipulation" that claimant's vascular condition is compensable, the dissent cites no authority, no do we know of any, supporting its position. Based on Georgia-Pacific v. Piwowar, 305 Or 494 (1988), Johnson v. Spectra Physics, 303 Or 49 (1987), and their progeny, however, we conclude that more than a Notice of Closure is required to constitute an "official" acceptance of a condition.

Rate of permanent disability award

The Referee also relied on on our decision in Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), and concluded that any remaining amounts due on the 17 percent scheduled permanent disability awarded by the Order on Reconsideration should be paid at the rate of $305 per degree. In Herron, supra, the Board held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. However, subsequent to the Referee's order and our Order on Review, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992), rev den 315 Or 271 (1992).

Here, claimant was injured before May 7, 1990. Therefore, amended ORS 656.214(2) does not apply. Consequently, we conclude that claimant is instead entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former 656.214(2). Accordingly, we reverse the Referee's order as to the rate of scheduled permanent disability.

ORDER

The Referee's order dated November 25, 1991 is reversed in part and affirmed in part. That portion of the Referee's order directing the SAIF Corporation to pay amounts due on claimant's scheduled permanent disability award at the rate of $305 per degree and an out-of-compensation attorney fee payable from that increased compensation is reversed. The remainder of the order is affirmed.

**Board Member Hooton concurring and dissenting.**

This case involves a request for Board review on the issue of extent of scheduled permanent partial disability, and the rate of disability. On the question of the rate at which scheduled permanent partial disability is to be paid, I concur with the result reached by the majority. SAIF v. Herron, 114 Or App 64 (1992). On the question of extent of disability, however, I do not agree.

Claimant alleges an entitlement to permanent partial disability compensation for vascular insufficiency as a result of multiple surgeries to correct his accepted meniscal tear and laxity of the posteromedial joint capsule of the left knee. The Referee found, in reasoning adopted by the majority, that claimant failed to demonstrate a compensable relationship between the accepted knee conditions and the vascular insufficiency. Because the Referee and the majority have declined to consider the most relevant and meaningful evidence in the record, they have reached an erroneous conclusion, as a matter of law and of fact. It is from this conclusion, and the erroneous reasoning adopted by the majority that I dissent.

In SAIF v. Tull, 113 Or App 449 (1992) the Court of Appeals concluded that acceptance of a claim or condition is a question of fact to be determined based on all the evidence and not necessarily limited to the specific provisions of a particular form. Consequently, in deciding whether claimant's vascular insufficiency is related to the compensable claim, we must begin by deciding whether SAIF has accepted the condition. If it has, claimant need not prove the relationship, since the relationship is established as a matter of law. If it is not an accepted condition, the condition must be deemed de facto denied and claimant is entitled to an assessed fee for establishing the relationship to the compensable injury. I conclude that SAIF accepted the condition, and may not now deny its compensability or relatedness absent the issuance of a back-up denial.

Claimant was injured on August 14, 1989. On August 23, 1989 Dr. Carpenter performed a partial menisectomy of the medial meniscus of the left knee. (Ex. 5). This surgery left claimant with residual joint laxity and led to the insurer's acceptance of a partial in substance tear of the anterior cruciate ligament, as well as a tear of the posterior horn of the medial meniscus. (Ex. 7). On March 26, 1990, Dr. Carpenter performed a mid-patellar tendon graft and anterior cruciate ligament reconstruction. Thereafter, claimant experienced symptoms arising from a vascular insufficiency as early as July 9, 1990. (Ex. 10). At the request of Dr. Carpenter, claimant was examined by Dr. Didelius at the Walla Walla Clinic, who diagnosed chronic venous insufficiency on September 4, 1990. (Ex. 12). SAIF never formally accepted or denied this condition. However, the remainder of the record demonstrates that SAIF Corporation considered the condition compensably related and ultimately accepted the condition by stipulation on March 7, 1991.

After July 9, 1990, the major cause of claimant's ongoing need for treatment was the chronic swelling of his knee. At that time, claimant had participated in physical therapy related to his anterior cruciate ligament reconstruction, and had been fitted with a lennox hill brace. Dr. Carpenter, in the only causal statement the record contains on this issue, attributed his chronic swelling to the tourniquet effect of the brace. Dr. Carpenter has neither modified nor retracted that statement of causal relationship. As the only evidence on causation in the record, that opinion is uncontroverted and sufficient to establish the relationship the majority deems to be lacking. It is apparent that SAIF treated it accordingly and therefore accepted the claimant's chronic venous insufficiency.

SAIF Corporation continued to provide medical care and time loss through January 29, 1991. (Ex. 15). While I acknowledge that the mere payment of compensation does not constitute an acceptance of the condition, ORS 656.262(9), SAIF Corporation has done more than merely pay compensation in this instance.

On March 7, 1991 SAIF chose to close this claim pursuant to the insurer closure provisions of ORS 656.268(4). SAIF is a large insurer whose sole business is providing coverage for injured workers pursuant to the Workers' Compensation Law. As such, they may be deemed aware of the requirements for entitlement to time loss and permanent partial disability compensation. One such requirement is the relationship of the condition for which benefits are provided to the injurious event.

While temporary disability compensation must be paid regardless of ultimate compensability unless the claim is actually denied, giving rise to the special classification of "interim compensation," ORS 656.262(2), no such requirement exists for permanent disability compensation. To be entitled to scheduled permanent partial disability, claimant must experience a loss of use or function related to the injury, directly or indirectly, at the requisite level of contribution. ORS 656.005(7).

Neither is a Notice of Closure the same as a Determination Order.[1] A Determination Order is an order of the Department which either the claimant or the insurer/employer may appeal. A determination of the Department that the requisite relationship has, or has not, been established, is not final for either party until the time for appeal on that order has run. A Notice of Closure, however, is the stipulation of the insurer, or self-insured employer, regarding the entitlement of the claimant to permanent partial disability compensation for his accepted conditions. The Notice of Closure, completed by the SAIF Corporation on March 7, 1991 contains the following stipulation:

> "You are entitled to compensation for permanent partial disability as follows:
>
> 54 percent of the left knee (BPC 513L), equal to 81 degrees. The total value of this award is $11,745.00." (Ex. 15, emphasis added).

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[1] The majority finds Gloria T. Olson, 44 Van Natta 2519 (1992) "instructive." Because that case involved a Determination Order, we argued that the insurer's decision to allow an "erroneous" order to stand did not constitute an acceptance. That, however, is in no way similar to or instructive in the present situation where the insurer, on its own, determined whether, and why, claimant was entitled to disability compensation. The first is a litigation decision and our decision promotes settlement. The second is a stipulation (I can think of no other name for it) and the insurer should be required to live by it.

The parties have stipulated that the medical evidence supports an entitlement to compensation for permanent disability as a result of claimant's partial menisectomy in the amount of 5 percent pursuant to OAR 436-35-230(4)(d); 10 percent for knee joint instability pursuant to OAR 436-35-230(3); and 2 percent for loss of range of motion pursuant to OAR 436-35-220(1), for a total of 16 percent scheduled permanent partial disability of the left knee. A review of the record indicates that these values are appropriate.

In addition, as the Referee also found, the record demonstrates that claimant suffers residual weakness, and chronic venous insufficiency. If claimant's weakness were compensable under the terms of OAR 436-35-230(5)(b), it would entitle claimant to a maximum additional award of 10 percent. That additional award is not sufficient to account for SAIF's initial determination that claimant was entitled to 54 percent scheduled permanent partial disability compensation. The sole remaining impairment, and the only impairment that is significant enough to account for the additional entitlement, is claimant's chronic venous insufficiency. Consequently, it is not only reasonable, but absolutely necessary to infer that at the time of issuance of the Notice of Closure, SAIF Corporation acknowledged the compensability of, and ultimately accepted, claimant's chronic venous insufficiency.

Having accepted the condition by a specific and unambiguous legal act, SAIF may not now assert that the chronic venous insufficiency is not an accepted condition without the issuance of a back-up denial consistent with ORS 656.262(6).

Further, the Referee erred in his determination that claimant had failed to demonstrate the relatedness of the chronic venous insufficiency to the accepted claim. The only evidence in the record on causation supports compensability. In addition, we have consistently applied the stipulations of the parties, in lieu of evidence to support the necessary findings of fact. Having stipulated that the claimant was entitled to 54 percent scheduled permanent partial disability, SAIF could only challenge, correct, or withdraw that stipulation by requesting reconsideration of the Notice of Closure, or by issuance of a back-up denial. It did neither. The Department, the Referee and this Board are without authority to reduce claimant's scheduled permanent partial disability award below the 54 percent SAIF specifically acknowledged him to be entitled.

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March 12, 1993 Cite as 45 Van Natta 460 (1993)

In the Matter of the Compensation of
**DANIEL V. CRAWFORD, Claimant**
WCB Case No. 91-12411
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The self-insured employer requests and claimant cross-requests review of Referee Hazelett's order that awarded claimant 18 percent (1.8 degrees) scheduled permanent disability for the loss of use or function of the ring finger of the right hand, whereas an Order on Reconsideration awarded none. In its brief, the employer contends that the Referee erred in: (1) admitting Dr. Layman's reports concerning an examination that he performed after issuance of the medical arbiter's report; and (2) permitting claimant to testify at hearing concerning the level of his impairment. On review, the issues are evidence and extent of scheduled permanent disability. We vacate.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant injured his hand in June 1990. The claim was accepted and closed by Determination Order on October 26, 1990, with no permanent disability award. Claimant requested reconsideration of the determination in April 1991 and specifically indicated his disagreement with the impairment findings of his attending physician. (Ex. 13).

The Department scheduled claimant for an examination by a medical arbiter, Dr. Gritzka; however, claimant objected to the examination stating that he never requested it. On August 30, 1991, the Department issued an Order on Reconsideration affirming the Determination Order.

Dr. Gritzka's examination was scheduled after issuance of the Order on Reconsideration, but claimant did not attend. Dr. Gritzka reviewed claimant's medical file and issued a report on September 23, 1991. Claimant requested a hearing on the Order on Reconsideration.

At hearing, the employer's counsel objected to admission of Dr. Gritzka's report. Noting that claimant had earlier objected to the medical arbiter's examination, the employer's counsel asserted that claimant had waived any challenge to his attending physician's impairment findings and that Dr. Gritzka's report is, therefore, irrelevant. Claimant responded that Dr. Gritzka's report should be admitted and considered by the Referee in rating permanent disability. The Referee admitted Dr. Gritzka's report into evidence.

## CONCLUSIONS OF LAW AND OPINION

We begin by addressing the validity of the Director's Order on Reconsideration. ORS 656.268(7) requires the Director to refer a claim to a medical arbiter if a party's objection on reconsideration to a determination order is based on a disagreement with the impairment findings used in rating the worker's disability. We have held that, under this statute, an Order on Reconsideration is invalid if the basis for objection is to the impairment findings and the Director fails to appoint a medical arbiter or submit the arbiter's findings for reconsideration. See Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

However, the Director's failure to comply with this mandatory procedure results in a voidable order, rather than one that is void ab initio. Brenton R. Kusch, 44 Van Natta 2222 (1992). The party that requested reconsideration of a Determination Order and objected to the impairment findings may, at hearing, withdraw any objection to the impairment findings and thereby waive the right to examination by a medical arbiter. In such cases, the Order on Reconsideration is not declared invalid. See Randy M. Mitchell, 44 Van Natta 2304 (1992).

Here, we find that claimant objected to the impairment findings in his request for reconsideration. When a medical arbiter was appointed pursuant to ORS 656.268(7), claimant objected to that procedure, apparently waiving his challenge to the impairment findings. However, when the medical arbiter issued his report, claimant specifically sought to have it admitted for the Referee's consideration.

The admission of the medical arbiter's report is inconsistent with the waiver of an objection to the impairment findings. ORS 656.268(7) makes the appointment of a medical arbiter conditional on claimant's objection to impairment findings. That is, a medical arbiter is not appointed, nor is a medical arbiter report issued, unless claimant objects to his attending physician's impairment findings. Therefore, we conclude that by seeking the admission of the medical arbiter report, claimant maintained an objection to the impairment findings and did not waive his right to a medical arbiter.

Under these circumstances, we find that the Director failed to follow the mandatory reconsideration procedure in ORS 656.268(7) by issuing the Order on Reconsideration without considering the medical arbiter report. Because we have found that claimant did not waive his right to a medical arbiter, we conclude that the Order on Reconsideration is invalid and that jurisdiction over this matter still lies with the Director.[1] See Olga I. Soto, supra.

Given our conclusion that the Order on Reconsideration is invalid, we need not address the employer's evidentiary challenge to Dr. Layman's reports.

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[1] ORS 656.268(6)(a) was amended in 1991 to allow the admission of a medical arbiter report into evidence at hearing, if the report was not prepared in time for the reconsideration proceeding. However, that amendment only applies to requests for reconsideration made after October 1, 1991. See Or Laws 1991, ch 502, § 1. Because claimant's request for reconsideration was made before that date, the amendment does not apply here.

ORDER

The Referee's order dated January 7, 1992, as amended January 31, 1992, is vacated. Claimant's hearing request is dismissed.

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March 12, 1993 Cite as 45 Van Natta 462 (1993)

In the Matter of the Compensation of
**MELVIN L. DORSON, Claimant**
WCB Case No. 92-03738
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Myzak's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) assessed a penalty and related attorney fee for its allegedly unreasonable denial. On review, the issues are aggravation, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not her second "Finding of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's reasoning and conclusion that claimant has proven by a preponderance of the evidence a worsened condition resulting in diminished earning capacity. Accordingly, we agree that claimant has established an aggravation of his low back condition.

Penalties

The Referee assessed a penalty against SAIF pursuant to ORS 656.262(10). In assessing a penalty, the Referee found that SAIF's denial was unreasonable "on its face," and that SAIF had "no evidence" to support its denial. SAIF contends that its denial was not unreasonable as it was under legitimate doubt as to its liability for claimant's alleged worsening. We agree and reverse.

A penalty for unreasonable denial may be assessed against an insurer or self-insured employer for unreasonable delay or refusal to pay compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

First, we do not find SAIF's "admission" that claimant experienced "a temporary increase in symptoms" to be a concession that claimant's condition worsened. Increased symptoms establish a compensable worsening only if they result in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986). Where a claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8). Here, SAIF expressly denied that claimant's condition had worsened since the last award or arrangement for compensation. Because claimant had received a previous permanent disability award, SAIF legitimately could deny his aggravation claim on that basis.

Moreover, nothing in the chart notes or reports authored prior to SAIF's December 1991 denial suggested that claimant's condition had worsened, as distinguished from a waxing and waning of his

symptoms. Neither did those documents establish that claimant was unable to work due to a worsened condition. Dr. Kaye, claimant's attending physician, noted claimant's continuing back and leg pain and sought authorization for palliative treatment. Dr. Breen, Industrial Medicine physician, examined claimant in June 1990 and obtained a CT scan. He did not opine whether claimant's condition had worsened or whether he was unable to work due to a worsened condition. Similarly, Dr. Hubbard, consulting neurosurgeon, reported in December 1990 that claimant had chronic low back pain with periodic flareups.

Accordingly, we find that SAIF had a legitimate doubt concerning its liability for claimant's alleged worsening. Consequently, a penalty is not warranted under these circumstances.

Attorney Fee on Board Review

Inasmuch as SAIF has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable 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 attorney fee for claimant's counsel's services on review concerning the aggravation 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 of the interest involved. We note that no attorney fee is available for that portion of claimant's counsel's services devoted to the penalty and attorney fee issues.

ORDER

The Referee's order dated June 30, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which assessed a penalty against the SAIF Corporation is reversed. For services on review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of $700, to be paid by SAIF. The remainder of the Referee's order is affirmed.

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March 12, 1993 Cite as 45 Van Natta 463 (1993)

In the Matter of the Compensation of
**ERWIN L. FARMEN, Claimant**
WCB Case Nos. 92-01495 & 92-01494
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee Quillinan's order that set aside a Director's order finding claimant ineligible for vocational assistance. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Additional Facts," with the following supplementation.

Claimant was unable to return to his job-at-injury as a welder, due to back pain caused by his compensable injury. (See Ex. 25-1). Therefore, he worked as an apartment manager, for minimal wages.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the Director's order finding claimant ineligible for vocational assistance, based on her conclusion that the Director abused his discretion in considering the minimal wages paid for claimant's post-injury job (apartment manager), rather than the more substantial wages claimant earned in his gainful at-injury employment (welder). The Referee reasoned that OAR 436-120-005(6)(b), which the Director relied upon to consider claimant's nominal post-injury wages, is invalid because it conflicts with ORS 656.340(5). Therefore, the Referee concluded that the Director violated the statute by relying on the rule. We agree.

The question presented is whether the Director's January 22, 1992 order applying that rule should be modified because it conflicts with the governing statute. See ORS 656.283(2)(a); Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992).

ORS 656.340(5) provides:

> "The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury." (Emphasis Added).

ORS 656.340(6) provides, in relevant part:

> "(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available or suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment. (Emphasis Added).
>
> "(b) As used in this subsection:
>
> "(A) A 'substantial handicap to employment' exists when the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.
>
> "(B) 'Suitable employment' means:
>
> "* * *
>
> "(iii) Employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment."

OAR 436-120-005(6)(b) provides:

> "'Regular employment' means employment of the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance[.]" (Emphasis Added).

Under the Director's rule, the wage comparison for evaluating a request for vocational assistance depends on which employment, the job-at-injury or the job-at-aggravation, "gave rise to the eligibility for vocational assistance." OAR 436-120-005(6)(b). In this case, because claimant was ineligible for vocational assistance after his initial injury, the Director reasoned that "[t]he aggravation gave rise to this period of potential eligibility[.]" (Ex. 25-3-4). Therefore, the Director found that claimant's job-at-aggravation, as an apartment manager, was claimant's "regular work" under the rule. (Ex. 25-4). It is undisputed that, as an apartment manager, claimant was earning wages beneath the Oregon minimum wage. (Ex. 25-5). Finding that jobs paying within 20 percent of minimum wage are available to claimant without retraining, the Director concluded that claimant is ineligible for vocational assistance.

Claimant contends that his initial injury was the actual cause of his inability to return to his job-at-injury as a welder. Because the post-injury apartment manager job did not cause him to have the "substantial handicap to employment," from which he suffers, and did not contribute whatsoever to his handicap, claimant argues that it did not "give rise" to his present potential eligibility for vocational assistance. Claimant further argues that OAR 436-120-005(6)(b), defining "regular employment" as claimant's job-at-aggravation, has the effect here of contradicting the statutory objective of vocational assistance of returning the worker to employment "as close as possible to his regular employment at a wage as close as possible to the worker's wage at the time of injury." See ORS 656.340(5) (Emphasis added). Thus claimant argues that the Director's rule, as applied to claimant in this case, conflicts with the vocational assistance statutes. We agree.

There is evidence that claimant would likely be eligible for vocational assistance, if the Director considered the wages he earned in his "regular employment" as a welder. (See Tr. 6). The Referee's

finding to that effect is undisputed on review. (See O&O p. 2). Moreover, claimant's present inability to return to his job-at-injury is established. (See Ex. 21); OAR 436-120-040(7) & 436-120-045(3); Colclasure v. Washington County School Dist. No. 48-J, 117 Or App 128 (1992). Under these circumstances, we conclude that claimant is entitled to vocational assistance if suitable employment, i.e., paying within 20 percent of wages currently paid for claimant's regular work as a welder, is not available. See ORS 656.340(6)(b)(B)(iii).

In reaching this conclusion we note that, pursuant to the Director's application of OAR 436-120-005(6)(b), a worker earning substantially more than minimum wage at injury, who returns to work at the minimum wage rate after the injury, effectively loses his eligibility for vocational assistance because he chose to return to work at nominal wages rather than remain completely idle. We find no indication that the legislature intended such an anomalous result. We conclude that as applied to claimant, the Director's rule defeats the express statutory objectives of vocational assistance, and effectively alters the statutes' eligibility requirements. See David F. Meissner, 45 Van Natta 249 (1993) (Where we distinguished between the Director's authority to establish conditions for provision of vocational assistance and his lack of authority to enlarge or limit the statutory eligibility requirements). Accordingly, because the eligibility prerequisites of ORS 656.340 are satisfied, but the Director's order countermands claimant's eligibility, the order must be modified. See ORS 656.283(2).

Finally, we note that the Referee purported to remand the claim to the Department. However, the Referee and the Board's authority is limited to modification of the Director's order. ORS 656.283(2); John R. Coyle, 45 Van Natta 325 (1993). Consequently, we modify the Director's order to direct the insurer to provide cliamant the vocational assistance he would receive based on his at-injury work as a welder.

ORDER

The Referee's order dated April 27, 1992 is modified. The Director's order is set aside and the claim is remanded to the insurer for further action consistent with this order.

**Chair Neidig dissenting.**

I respectfully disagree with the majority's conclusion that the Director has violated a statute by declining claimant's request for vocational assistance. See ORS 656.283(2)(a). As discussed in my dissenting opinion in David F. Meissner, 45 Van Natta 249 (1993), the court has recognized that the Director has broad discretion in determining an injured worker's eligibility for vocational assistance. See Peacock v. Veneer Services, 113 Or App 732, 735 (1992). I submit that the Director was acting within that broad discretion in declining claimant's request.

Here, the Director has concluded that claimant is not entitled to vocational assistance because he has not suffered a "substantial handicap to employment." See ORS 656.340(6)(b). In reaching this conclusion, the Director has reasoned that claimant is capable of employment which would produce a wage within 20 percent of the wages to which he was receiving in his regular employment at the time of his claim for vocational assistance. See ORS 656.340(6)(b)(B); OAR 436-120-005(6)(b).

The majority holds that the Director's decision essentially violated the eligibility requirements of ORS 656.340(6) in that the Director based the question of whether claimant has suffered a "substantial handicap" on claimant's employment at the time of his aggravation claim (which gave rise to his vocational assistance request) as opposed to his employment at the time of his initial injury. I suggest that the majority miscontrues the statute.

ORS 656.340(6)(a) sets forth two basic criteria concerning eligibility for vocational assistance: (1) the worker will not be able to return to the previous employment or to any other available or suitable employment with the employer at the time of injury; and (2) the worker has a substantial handicap to employment. The first criteria refers to claimant's employment at the time of injury. However, the second criteria is not dependent on "at-injury" employment. Rather, that requirement is premised on "substantial handicap to employment," which is defined as an incapacity to perform "suitable employment" (employment producing wages within 20 percent of current wages in the worker's regular employment). See ORS 656.340(6)(b)(A),(B)(iii). Since the statute has not defined "regular employment," the Director has promulgated rules which provide that the term "means employment of the kind the worker held at the time of the injury or the claim for aggravation." OAR 436-120-005(6)(b).

My review of the aforementioned statutory scheme persuades me that the Director's decision was not only within his broad discretion to set "nature and extent" conditions for providing vocational assistance (ORS 656.340(9)(c)), but was consistent with the "substantial handicap to employment" prong of the eligibility criteria in ORS 656.340(6)(a). Consequently, I do not consider the Director's decision to deny claimant's request for vocational assistance to constitute a violation of the Director's statutory authority.

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March 12, 1993 Cite as 45 Van Natta 466 (1993)

In the Matter of the Compensation of
**JOHN R. HEATH, Claimant**
WCB Case No. 91-14829
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The insurer requests review of that portion of Referee Hoguet's order that: (1) awarded claimant additional temporary total disability benefits; and (2) assessed a penalty for the insurer's allegedly unreasonable resistance to the payment of compensation. Claimant cross-requests review of that portion of the order that concluded that his claim had not been prematurely closed by a January 3, 1991 Determination Order. On review, the issues are premature closure, temporary disability and penalties. We affirm in part, reverse in part, and modify in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's claim had not been prematurely closed and, therefore, reinstated the January 3, 1991 Determination Order. The Referee based his decision primarily on the opinions of the Orthopaedic Consultants and Dr. Fuller, who concluded that claimant was medically stationary at the time of closure. Nonetheless, because the January 3, 1991 Determination Order had been rescinded by a May 17, 1991 Order on Reconsideration, the Referee ordered the insurer to pay temporary disability benefits from the date of closure until December 2, 1991, the date of the Referee's order. The Referee also assessed a penalty equal to 25 percent of the temporary disability "then due" between May 17, 1991 and October 14, 1991, the date of the insurer's hearing request from the Order on Reconsideration.

### Premature Closure

Claimant contends that the Referee erred in relying on the opinion of Dr. Fuller, who examined claimant some 10 months after the January 3, 1991 Determination Order. He argues that the question of whether he was medically stationary must be judged solely by evidence available at the time of closure. We disagree.

In determining whether a claim was prematurely closed, the question is whether the worker's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, contrary to claimant's contention, medical evidence developed after closure that addresses the worker's condition as of the time of closure may be considered. Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987). In this case, Dr. Fuller reviewed the medical record and opined that claimant was medically stationary as of January 3, 1991. The Referee properly considered that evidence in reaching his determination that the claim had not been prematurely closed. After our review of the record, we agree with the Referee's conclusion and, as supplemented herein, affirm and adopt that portion of his order.

Temporary Total Disability

The insurer contends that the Referee erred in concluding that claimant was procedurally entitled to temporary disability benefits between January 3, 1991, the date of the Determination Order, and December 2, 1991, the date of the Referee's order. First, it argues that, because it appealed the May 17, 1991 Order on Reconsideration, it was obligated to pay only those benefits that accrued from the date of that order. We agree.

As amended by the 1990 legislature, ORS 656.313(1)(a)(A) provides that the filing by an insurer of a request for hearing on a reconsideration order "stays payment of the compensation appealed, except for [t]emporary disability benefits that accrue from the date of the order appealed from until * * * the order appealed from is itself reversed[.]" Accordingly, the insurer was required to pay only those temporary disability benefits that accrued from May 17, 1991, until the Referee set aside the Order on Reconsideration.

The insurer also contends that its obligation to pay those accrued benefits was excused by virtue of the fact that a valid aggravation claim had been made and denied in February 1991. We disagree. Even if we assume that claimant had filed a valid aggravation claim under ORS 656.273(1), that claim, as well as the insurer's subsequent denial, was effectively rendered moot by the May 17, 1991 Order on Reconsideration, which set aside the January 3, 1991 Determination Order and reopened claimant's claim. Although that Order on Reconsideration was later reversed, the insurer was obligated at that time to process the claim under that decision. Accordingly, we conclude that, as a procedural matter, claimant was entitled to payment of temporary disability benefits that accrued from the date of the May 17, 1991 Order on Reconsideration until the Referee's December 2, 1991 order.

We add, however, that we have determined that claimant was medically stationary on January 3, 1991. Accordingly, although claimant was procedurally entitled to additional benefits past the medically stationary date due to the processing of the claim, he is not substantively entitled to them. Lebanon Plywood v. Seiber, 113 Or App 651 (1992). (A worker is substantively entitled to temporary total disability benefits from the onset of disability until the condition becomes medically stationary.) Moreover, because the payment of benefits past the medically stationary date is a consequence of the administrative process of claim closure and not an entitlement, we have no authority to impose payment of benefits past January 3, 1991. Lebanon Plywood v. Seiber, supra.

Penalties

Although we lack the authority to order the insurer to pay claimant the additional temporary disability benefits to which he was procedurally entitled, we conclude that the insurer's failure to commence payment of temporary disability benefits which were procedurally due within 14 days of the May 17, 1991 Order on Reconsideration amounted to an unreasonable resistance to the payment of compensation. See ORS 656.262(4)(a), 656.268(3). Accordingly, we modify the Referee's order to assess a penalty equal to 25 percent of the temporary disability benefits "then due" from May 17, 1991 through November 5, 1991, the date of hearing, with one-half of the penalty payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Attorney Fee - Board Review

Inasmuch as penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review concerning the penalty issue. Saxton v. SAIF, 80 Or App 361 (1986).

ORDER

The Referee's order dated December 2, 1991 is affirmed in part, reversed in part and modified in part. That portion of the Referee's order that awarded claimant additional temporary disability benefits is reversed. That portion of the order that assessed a penalty is modified to assess a penalty equal to 25 percent of temporary disability benefits accruing from May 17, 1991 through November 5, 1991, to be equally divided between claimant and his attorney. The remainder of the order is affirmed.

**Board Member Hooton specially concurring.**

I agree that the majority's resolution of the temporary total disability issue is required by Lebanon Plywood v. Seiber, 113 Or App 651 (1992). However, I am not convinced that the court anticipated the present result when it decided that case. In Seiber, the Board awarded temporary disability compensation after closure of the claim and payment of any permanent partial disability due. At that point, the award of temporary disability for the period between the medically stationary date and the date of closure would produce an overpayment for which the insurer was deprived of any method of obtaining repayment. The court decided that in such a fact situation, the Board lacked the authority to create an overpayment.

In the present claim, the insurer processed the claim to closure. The claimant challenged the closure and the Department determined that the claim had been prematurely closed and set aside the Determination Order. As of the date the Determination Order was set aside, the claimant became entitled to the resumption of temporary disability benefits. The insurer requested a hearing from the Order on Reconsideration, thus implementing the provisions of ORS 656.313(1). Under those provisions the insurer was entitled to stay the payment of compensation due for the period during which the claim was closed. However, ORS 656.313(1) does not allow the insurer to stay the payment of ongoing temporary disability obligations. Those obligations continued until the Order on Reconsideration was set aside at hearing, and the Determination Order reinstated. The insurer, without justification, ignored the requirements of ORS 656.313(1) and declined to pay ongoing temporary disability.

The importance of that ongoing payment obligation is emphasized by the legislature in ORS 656.313(2), which provides that the insurer has no right to recover compensation paid pending its appeal of an award. Nevertheless, the Court of Appeals has concluded that we are without authority to order the payment of temporary disability to which the claimant was procedurally entitled, but to which the claimant retained no substantive entitlement as a consequence of the outcome of litigation before the Board. It argues that the appropriate method of obtaining compliance is to allow a penalty on the amount of temporary disability which should have been paid, but which the insurer did not pay.

In all seriousness, this Board Member, and every claimant whose compensation is subsequently held hostage, must question the wisdom of the court's interpretation of the limitations on the Board's authority. Because the penalty represents only 25 percent of the amount the insurer should have paid, but did not pay, the insurer is economically much better off to thwart the requirements of the law and accept the penalty. By doing so, it avoids the payment of 75 percent of the nonrecoverable temporary disability obligation the legislature demanded that it must pay, by accepting the payment of a 25 percent penalty. The court's interpretation makes it profitable to defy the statutory requirements.

ORS 656.295(6) defines the limits of the Board's authority. It states that the Board may "make such disposition of the case as it determines to be appropriate." So long as that disposition is consistent with the legislative scheme and accomplishes the purposes for which the Workers' Compensation Law was adopted, any resolution of any claim is within the Board's authority. The limitation imposed by the court in Seiber prevents the Board from obtaining compliance with the provisions of ORS 656.313(1) by making conduct in violation of law more profitable than compliance.

In this case, solely because of the interpretation of the court, illegal conduct actually does pay.

In the Matter of the Compensation of
**DELTON A. JOHNSON, Claimant**
WCB Case No. 91-08029
ORDER ON REVIEW
C. David Hall, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Thye's order which affirmed an Order on Reconsideration awarding 25 percent (5.5 degrees) scheduled permanent disability benefits for loss of use or function of the right middle finger due to amputation. On review, the issue is extent of scheduled permanent disability.

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

Claimant asserts that he is entitled to compensation for cold sensitivity that is a result of his injury. We find there is no standard contained in the Director's rules that allows an award for cold sensitivity due to an an amputation. Further, we are without authority to adopt such a standard or to remand to the Director for that purpose. Gary D. Gallino, 44 Van Natta 2506 (1992).

ORDER

The Referee's order dated January 15, 1992 is affirmed.

**Board Member Hooton specially concurring.**

I agree with the resolution of the question whether the parties may stipulate to the applicable law so as to permit the Referee to extend the scheduled disability award beyond the standards on a showing of clear and convincing evidence. Such a stipulation is impermissible. See, e.g., Randal L. Brown, 44 Van Natta 1726 (1992).

The purpose for the stipulation in the present claim, however, raises an additional issue. The medical evidence indicates that claimant experiences a hypersensitivity to cold which prevents or limits his ability to return to his previous occupation. Dr. Nathan evaluated claimant's complaints and concluded that the hypersensitivity to cold was sufficiently severe to warrant an additional 10 percent of scheduled permanent partial disability. That evidence is unrebutted.

In the Order on Reconsideration the Department failed to discuss claimant's hypersensitivity as a potential basis for an award of disability, but applied the standard for loss of sensitivity, a standard that is decidedly inappropriate. The Department made no findings regarding whether claimant suffered impairment not covered by the standards.

I would take note of the fact that we are discussing a partial amputation of the right middle finger. The value to be allowed for a 25 percent permanent partial disability is only 5.5 degrees, payable at a rate of $145 per degree. An additional 10 percent is equal to 2.2 degrees for a dollar value of $319.00. This is not an award for which it is appropriate to seek the assistance of the Circuit Court to obtain the adoption of a rule. Neither is it an award which is sufficient to justify the attorney's time and expense for services on Board review and at the court, services for which he cannot be compensated satisfactorily, even if he wins. A fee equal to 25 percent of the increased compensation limits claimant's attorney to a fee of $79.75 for any work necessary to establish this claimant's entitlement to an appropriate award of compensation. Unfortunately, the process of insuring that claimant has received a proper award under the current law will likely be repeated for similarly limited compensation over and over and over again.

The attorney is to be commended for his efforts in seeking an avenue of dispute resolution that minimizes the necessity for litigation. It is unfortunate that the solution which offered itself is not legally permissible. Nevertheless, on this record, it is clear that the Department should have adopted a rule, or at the very minimum, made findings explaining why the current rules were sufficient to fully compensate claimant. The very fact that it did not has placed claimant in the position of searching for an expedient and inexpensive remedy.

Our recent decision in Gary D. Gallino, 44 Van Natta 2506 (1992), a decision which I find abhorrent for reasons adequately expressed in the dissenting opinions of Board members Gunn and Kinsley and in my own special concurrence in Olga I. Soto, on recon, 44 Van Natta 1609, 1610 (1992), eliminates our ability to fashion a remedy appropriate to this claimant. It is unfortunate that the only mechanism for relief is a request for review to the Court of Appeals, seeking remand to the Director for the adoption of an appropriate rule, a relief mechanism that further taxes the system, and placing this attorney in the position of having to decide whether to further appeal a decision that has already required greater services than he could possibly be compensated for.

ORS 183.482 provides the standard of review for orders in contested cases. The court may remand the order if it finds that the order is not supported by substantial evidence. Because we have decided that we cannot review the decision of the Director regarding whether the adoption of a temporary rule was appropriate in a particular disputed claim, we leave to the court the responsibility to determine whether the Director's order is sufficient for review under Armstrong v. Asten-Hill, 90 Or App 200 (1988), and whether the order is supported by substantial evidence. In the event that this case ever comes before the court, I freely express my opinion that no order of the Director that I have yet seen meets the Armstrong requirements, and in this case, the order is contrary to the only evidence in the record on point.

The legislature interposed the requirement of reconsideration and the possible adoption of temporary rules as a means of providing greater assurance that the award was correct and thereby thought to diminish the number of hearings required. That intent has been perverted into a system of litigation created, not by legislative mandate, but, by the interplay of the regulations of the Department and the unwillingness of the Board to accept responsibility for providing an efficient and just administrative system for the prompt delivery of benefits as required by ORS 656.012(2). It is time we accepted responsibility for the aberration we have created.

To this claimant, I express my heartfelt apology for what is obviously a rude miscarriage of justice.

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March 12, 1993 Cite as 45 Van Natta 470 (1993)

In the Matter of the Compensation of
**MURRAY L. JOHNSON, Claimant**
WCB Case No. 90-14793
ORDER ON REVIEW (REMANDING)
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of that portion of Referee Myzak's order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We remand.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

On June 29, 1990, SAIF denied an aggravation claim for claimant's current low back condition. The denial noted that SAIF would continue to provide medical benefits that were related to claimant's accepted condition. On July 19, 1990, the Hearings Division received claimant's hearing request, which noted the following issues: (1) compensability (industrial injury); (2) compensability (occupational disease); (3) aggravation; and (4) penalties and attorney fees.

At the March 8, 1991 hearing, claimant's counsel identified the issues as "an aggravation denial, and then apparently there's going to be a further denial." In response, SAIF orally amended its denial to "include a denial of his current condition as being related to the compensable injury." Neither party raised the compensability of claimant's condition as a new injury or occupational disease.

In addition to analyzing claimant's claim as related to his 1987 compensable injury, the Referee considered the claim as a new injury and as an occupational disease. The Referee determined that the medical evidence did not support a finding of either a resultant condition, consequential condition, or a new injury. Turning to an occupational disease theory, the Referee found that the major contributing cause of claimant's current condition were his work activities subsequent to his compensable injury. Therefore, the Referee held that claimant's condition was compensable as an occupational disease.

On review, SAIF argues that an occupational disease claim had not been raised by either party. Consequently, it contends that the Referee exceeded the scope of her review. We disagree. See Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458 (1991).

In Alonzo, the court held that, when a carrier had raised an "offset" issue in its pleadings, the Board could consider the issue notwithstanding a carrier's failure to raise the issue at hearing. On remand, we found that, in light of our prior unaltered finding which had reduced the claimant's temporary disability award, the carrier was entitled to to recover its temporary disability overpayment. Maria Alonzo, 43 Van Natta 963 (1991).

Here, claimant requested a hearing contesting SAIF's denial of his aggravation claim for a 1987 compensable low back injury. In submitting the request, claimant noted that one of the issues was "occupational disease." At hearing, the insurer amended its denial to include claimant's current condition as unrelated to the compensable injury. Although no mention was made of claimant's "occupational disease," the Referee analyzed claimant's condition under that theory.

In accordance with Alonzo, we hold that the occupational disease claim could be considered by the Referee. Nevertheless, such a conclusion does not end our inquiry. We must determine whether the record regarding this occupational disease issue is completely and sufficiently developed.

We may remand to the Referee if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

We have previously held that, when a referee analyzes a claim under a "new injury" theory rather than under the "aggravation" or "occupational disease" theories argued by the parties, the referee's ruling does not exceed the scope of the referee's review. Allen B. Cooper, 40 Van Natta 1915 (1988). In Cooper, we reasoned that the "new injury" theory was not a "new issue," but rather an alternative legal theory on the compensability issue raised by the claimant. Finally, noting that both parties had submitted evidence concerning the "new injury" while addressing the occupational disease theory, we determined that the employer had not been prejudiced by the referee's ruling.

Here, in contrast, the compensability theories advanced at hearing both pertained to claimant's current condition as related to his compensable 1987 low back claim. Unlike Cooper, no compensability theory expressly presented at hearing was premised on a "new" claim (either "new injury" or "occupational disease"). Moreover, with the exception of a few references to claimant's post-rehabilitation work activities, the medical evidence submitted by the parties does not address an "occupational disease" theory. In fact, the Referee essentially acknowledged this apparent deficiency in analyzing the medical opinions (particularly the opinion authored by Dr. Slack).

Under such circumstances, we consider the record regarding the "occupational disease" theory to be incompletely and insufficiently developed. See ORS 656.295(5). Furthermore, we find a compelling reason to remand this matter to the Referee for further evidence concerning the "occupational disease" theory.

Accordingly, the Referee's order dated August 2, 1991, as reconsidered August 22, 1991, is vacated. This matter is remanded to Referee Myzak with instructions to take additional evidence from both parties pertaining to the "occupational disease" theory. Such evidence may be taken in any manner that the Referee determines achieves substantial justice. Thereafter, the Referee shall issue a

In the Matter of the Compensation of
**JOHN P. LAMBERT, Claimant**
WCB Case Nos. 90-21305 & 90-21162
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Liberty Northwest Insurance Corporation, on behalf of West Coast Steel Fabricators (West Coast), requests review of that portion of Referee Livesley's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld Liberty Northwest's responsibility denial, on behalf of Willamette Poultry, of claimant's aggravation claim for the same condition. Claimant initially cross-requested review of the issue of temporary disability compensation, which he has since withdrawn. That request has been dismissed pursuant to our February 6, 1992 interim order. On review, the issue is responsibility. We affirm.

We correct the Referee's evidentiary rulings as follows. The report by Dr. Kitchel, originally numbered Exhibit 34, was renumbered as Exhibit 33, not 32.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Liberty Northwest, on behalf of West Coast Steel, denied responsibility for claimant's new injury claim on October 26, 1990, and, on behalf of Willamette Poultry, denied compensability and responsibility for claimant's aggravation claim on November 19, 1990.

No order designating a paying agent issued pursuant to ORS 656.307.

Claimant's accepted 1986 low back injury with Liberty/Willamette Poultry was an acute lumbar sprain-strain with muscle spasm, myositis, and radiculalgia.

In August 1990, Dr. Kitchel examined claimant and diagnosed focal disc protrusions at L4-5 and L5-S1, with foraminal stenosis at L5-S1, left side, based on an August 1, 1990 CT scan and radiating leg symptoms.

## FINDINGS OF ULTIMATE FACT

We adopt the Referee's findings of ultimate fact with the following supplementation.

The lifting incident on July 18, 1990 at West Coast Steel was a material contributing cause of claimant's subsequent disability and need for treatment.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

We affirm the Referee and adopt his recitation of the facts of the case but write to clarify the analysis.

The Referee applied ORS 656.308, which shifts responsibility to a later employer if the worker sustains a new compensable injury involving the same condition. Here, the medical evidence establishes that claimant's current protruded disc condition, although involving the low back, is a new

In 1986, when claimant was employed at Willamette Poultry, he experienced an acute lumbar sprain-strain with muscle spasm, myositis, and radiculalgia (neuralgia due to irritation of the sensory root of a spinal nerve). Claimant continued to experience low back pain, aggravated by bending and twisting, and sought treatment for a non-radiating low back strain in 1989 that resolved without permanent impairment.

On July 18, 1990, claimant hurt his low back at West Coast Steel while he was lifting a handrail to weld it. (Tr. 19, 36, 37). The symptoms for which he sought treatment consisted of right low back and right lateral thigh pain. Dr. Kitchel, orthopedic surgeon, diagnosed focal disc protrusions at L4-5 and L5-S1, with foraminal stenosis at L4-S1. Comparing claimant's current condition to that of 1987, after the Willamette Poultry injury, Dr. Kitchel opined:

> "While [claimant] certainly had a pre-existing problem with his back I believe his current need for treatment has been related to the July 18, 1990 injury when he was stooping and bending to roll a section of handrail while working for West Coast Steel . . . . I believe his current major need for treatment is related to that injury and not the injury which was suffered previously at Willamette Poultry." (Ex. 33).

Dr. Kitchel's comparison is supported by the medical evidence regarding claimant's 1986 lumbar strain. In addition, although a 1987 x-ray revealed some narrowing of the L4-5 disc space, there was no evidence of the focal protrusions at L4-5 and L5-S1 as revealed by the 1990 CT scan.

We are more persuaded by the opinion of Dr. Kitchel than that of Dr. Fuller, who performed an independent medical examination. Fuller diagnosed claimant's current condition as chronic degenerative disc disease that may have preexisted claimant's 1986 injury at Willamette Poultry. (Ex. 34). Fuller's check-the-box opinion is unpersuasive in light of Kitchel's comparison between the 1986 and 1990 conditions. Also, Fuller failed to account for claimant's medical history of recurring low back muscle strain and the absence of medical evidence of the protruding discs during that time.

We conclude there is no persuasive medical evidence that claimant's first injury at Willamette Poultry, even though it involved claimant's low back, contributed to his current disc condition. We find that the current disc condition arose directly from the 1990 lifting incident with West Coast. We also find that the 1990 lifting incident was a material contributing cause of the disc condition. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

Therefore, we conclude that claimant experienced a new accidental injury arising out of his employment at West Coast Steel for which he sought medical treatment. Because Liberty/West Coast was the insurer on the risk at that time, it is responsible for claimant's protruding discs and foraminal stenosis.

Temporary Disability Compensation

We hereby incorporate in this order our February 6, 1992 Interim Order of Dismissal, in which we dismissed claimant's cross-request regarding the issue of temporary disability compensation.

Attorney Fee

Although compensability was not raised as an issue on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992). Accordingly, claimant would be entitled to a reasonable assessed attorney fee under ORS 656.382(2) for legal representation on review. However, because claimant's attorney neither filed a brief nor documented some legal representation short of briefing, we decline to award an assessed attorney fee on review. Shirley M. Brown, 40 Van Natta 879 (1992).

ORDER

The Referee's order dated October 24, 1991 is affirmed.

In the Matter of the Compensation of
**DONNA L. McCOY, Claimant**
WCB Case Nos. 92-01372 & 91-08592
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Myers' order that: (1) set aside its denial of claimant's occupational disease claim for her current cervical condition; and (2) upheld United Employers Insurance Company's (UEI) denial of claimant's occupational disease claim for the same condition. SAIF also moves to strike UEI's "Respondent's/Cross-Appellant's Reply Brief." Claimant cross-requests review of those portions of the Referee's order that: (1) declined to assess penalties against SAIF and UEI for allegedly unreasonable denials of compensability; and (2) awarded an attorney fee of $1,750 for claimant's counsel's services at hearing. In its brief, UEI contends that the Referee erred by excluding Exhibit 34 from the record. On review, the issues are motion to strike, evidence, compensability, responsibility and penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to strike

On review, SAIF moves to strike UEI's August 24, 1992 brief titled "Respondent's/Cross-Appellant's Reply Brief." UEI's brief was filed after SAIF had filed its Reply/Cross-Respondent's Brief. SAIF notes that the Board's rules provide that a cross-reply brief may be filed, but only by a party who is a cross-appellant. See OAR 438-11-020(2). SAIF contends that UEI is entitled to file a respondent's brief but, because it did not file its own request or cross-request for review, UEI may not file a cross-reply brief.

We agree that UEI's brief has been submitted as a cross-reply brief and under the circumstances, will not be considered. See e.g., Guadalupe V. Gonzales, 43 Van Natta 589 (1991). Accordingly, SAIF's motion to strike UEI's "Respondent's/Cross-Appellant's Reply Brief" is granted.

### Evidence

On review, UEI argues that the Referee improperly excluded an April 29, 1992 report from Dr. Donahoo, an IME who reviewed Dr. Freeman's deposition and prepared a rebuttal report. UEI contends that it was only brought into the hearing as a party after late notice, and it expressly agreed to proceed to hearing if no "surprise issues" were raised. UEI argues that Exhibit 32, a report generated by Dr. Freeman, discussed a new theory of herniated disc, related to claimant's employment with its insured, and UEI should have been allowed to submit Dr. Donahoo's report in response, rather than just being permitted to cross-examine Dr. Freeman.

SAIF argues that the parties only held the record open to depose Dr. Freeman with an opportunity for UEI to move for another medical opinion. SAIF also contends that, if UEI was surprised by any theories or issues, its remedy was to move for a postponement or continuance at that time. SAIF argues that, because UEI chose to proceed, the Referee was within his discretion to only allow cross-examination, rather than a rebuttal report.

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

Here, we conclude that the Referee did not abuse his discretion by excluding the report of Dr. Donahoo. Because UEI chose to proceed at hearing without requesting a postponement or continuance, we do not find that it was an abuse of discretion for the Referee to close the record without allowing UEI to submit an additional medical report. Furthermore, we conclude that the manner in which the Referee conducted the hearing achieved substantial justice. Therefore, UEI's motion to reopen the record for admission of Dr. Donahoo's report is denied.

Compensability

We agree with the Referee that claimant has established compensability of her claim as an occupational disease. We adopt his "Conclusions of Law and Opinion" on that issue, with the following correction. Claimant treated with Dr. Peterson, M.D., and was also sent to Dr. Patterson, neurologist, for consultation. However, we find that the Referee intended to refer to Dr. Peterson on page 3 of the Opinion and Order. Accordingly, the Referee's references to Dr. Patterson on page 3, are changed to Dr. Peterson.

Responsibility

We agree with the Referee's conclusion that SAIF is responsible for claimant's occupational disease claim. However, we apply the following analysis.

We have held that ORS 656.308(1) is not applicable where there is no prior accepted occupational disease claim for the same condition and a determination must be made concerning the assignment of initial liability for a compensable condition between successive employers. See Fred A. Nutter, 44 Van Natta 854 (1992). Here, claimant's cervical condition has never been accepted. Accordingly, we conclude that the last injurious exposure rule applies to determine responsibility. Nutter, supra.

In an occupational disease context, the critical event for assigning responsibility is the "onset of disability." The onset of disability is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239 (1982).

Here, claimant sought chiropractic treatment for neck pain during her work for SAIF's insured. The Referee found that, although claimant first went to Dr. Peterson for her neck condition in April 1991 during her subsequent employment with UEI's insured, claimant sought such treatment only at the urging of her relatives who had been recommending for the past couple of years that she seek medical treatment for her problems. Claimant testified that her fall at UEI's insured during February 1991 did not worsen her neck condition, and there is no indication that her February 1991 fall was the reason she eventually sought medical treatment for her cervical condition. (Ex. 8-1). Claimant did not lose time from work for her neck condition until August 1991, when she underwent neck surgery.

In similar circumstances, we have concluded that the "onset of disability" is the point in time at which claimant's employment last contributed to the cause or worsening of the condition prior to the time loss. See Inez Horsey, 42 Van Natta 331 (1990); United Pacific Insurance v. Harris, 63 Or App 256 (1983); SAIF v. Guyton, 63 Or App 270 (1983). In Horsey, supra, we concluded that responsibility is assigned, where it can be determined, to the last employment prior to the time loss which actually contributed to the cause or worsening of the underlying disease.

Here, we agree with the Referee's conclusion that there is no persuasive evidence that claimant's employment with UEI or her fall in February 1991, actually contributed to the cause or worsening of her cervical condition. Both Dr. Peterson and Dr. Freeman believed that claimant's condition worsened after her fall at UEI's insured, but we agree with the Referee that those portions of the doctors' opinions were based upon a mistaken presumption, as claimant credibly testified that her condition remained the same after her fall. Dr. Dickerman, IME, believed only that claimant's symptoms could have been aggravated as a result of her fall, and Dr. Patterson, who saw claimant only for consultation purposes, was unable to relate her cervical condition to any of her work conditions, including her fall. (Ex. 20).

We conclude that the remaining medical opinion establishes that the last employment prior to time loss which actually contributed to the cause or worsening of claimant's cervical condition was her employment with SAIF's insured. In other words, UEI has established that claimant's employment with SAIF's insured was the sole cause of her condition. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). Accordingly, we agree with the Referee's conclusion that SAIF is responsible for claimant's cervical condition.

Penalties

Claimant contends that the Referee should have awarded penalties against both SAIF and UEI for their compensability denials because no legitimate basis existed for contending that the claim was not compensable as to at least one of the insurers. See SAIF v. Moyer, 63 Or App 498 (1983). We disagree.

Dr. Dickerman's report of May 31, 1991 stated that claimant had a cervical degenerative disease "not related to any work exposure" with SAIF's insured. Dr. Dickerman's report was issued before SAIF's and UEI's denial. Additionally, Dr. Patterson wrote to claimant on August 6, 1991 and reported that he could not specifically relate claimant's cervical condition to any previous work conditions, including the fall she suffered in February of 1991 at UEI's insured.

Under the circumstances, we conclude that a legitimate basis existed for concluding that the cervical condition was not compensable as to at least one of the insurers. We, therefore, affirm the Referee on the penalty issue.

Attorney fee/services at hearing

After considering the factors set forth in OAR 438-15-010(4), we conclude that the Referee's attorney fee award for claimant's counsel's services at hearing was reasonable. We, therefore, decline to increase the Referee's attorney fee award.

Attorney fee/services on review

Claimant is entitled to an attorney fee for prevailing over SAIF's request for 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 attorney's services on 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 claimant's respondent's brief), the complexity of the issues and the value of the interest involved. We further note that the responsibility portion of claimant's brief argued for responsibility to be assigned against UEI, rather than SAIF, whom we have found to be responsible. Finally, we note that no attorney fee is available for that portion of claimant's brief devoted to the issues of penalties and attorney fees. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 8, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $500, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**LARRY M. McFERRIN, Claimant**
WCB Case No. 92-01195
ORDER ON REVIEW
Margaret McGinnis, Claimant Attorney
Jim Booth (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of that portion of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's hypertension condition. On review, the issue is compensability.

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

Claimant argues on review that his alleged hereditary "predisposition" to hypertension cannot be considered for purposes of determining the major contributing cause of his condition. He cites Liberty Northwest v. Spurgeon, 109 Or App 566 (1991) as support for his assertion. After reviewing the medical record as a whole, however, we conclude that in the present case, we need not differentiate between "causes" and "predispositions," for there is insufficient medical evidence that the factors listed by Dr. Black are, in fact, "predispositions," rather than causes of claimant's hypertension.

ORDER

The Referee's order dated May 7, 1992 is affirmed.

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In the Matter of the Compensation of
**KENNETH G. MIZE, Claimant**
WCB Case No. 92-00725
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Spangler's order that found that claimant was a subject worker at the onset of his right carpal tunnel syndrome (CTS) condition. On review, the issue is whether claimant is a subject worker. We affirm.

## FINDINGS OF FACT

Claimant began practicing dentistry in 1981. At that time, claimant's business was a sole proprietorship, which paid workers' compensation premiums for its employees, excluding claimant. The SAIF Corporation provided coverage for the employees, but not for claimant.

In 1989, claimant incorporated his dentistry practice and became a corporate officer with 100 percent ownership. Based on claimant's belief that he would be individually covered by workers' compensation insurance, the employer corporation included claimant's wages in its calculation and payment of workers' compensation premiums. SAIF accepted the premiums.

The corporation at no time formally elected to provide workers' compensation coverage for claimant.

Claimant's work as a dentist since 1981 required repetitive use of his arms, wrists and hands. In 1991, claimant began experiencing intermittent pain and numbness in his right hand. He sought treatment with Dr. Molloy, who diagnosed CTS. Dr. Gabr, neurologist, examined claimant, noting positive Tinel's sign and sensory deficit. A nerve conduction study confirmed the right CTS diagnosis.

On December 5, 1991, claimant filed a claim for right CTS. SAIF denied the claim on the grounds that "there was no personal election coverage in effect." (Ex. 14-1).

## ULTIMATE FINDINGS OF FACT

Claimant was a subject worker at the time of the onset of his carpal tunnel syndrome.

Claimant's work activities as a dentist were the major contributing cause of his right CTS condition, as established by medical evidence supported by objective findings.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion," with the following supplementation concerning claimant's subject worker status.

The issue is whether, as an officer of his corporation, claimant was a subject worker at the time of his injury. We find that he was.

Prior to being amended in 1990, former ORS 656.027 provided that all workers are subject to ORS Chapter 656 except those specifically excluded by subsections 1 through 19 of the former statute. Among those excluded under the former law were corporate officers who were also directors of their corporations and who had a substantial ownership interest in the corporation, regardless of the nature of the work performed.

In 1990, former ORS 656.027(9) was amended to exclude:

> "Corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation * * * [subject to limitations not relevant here]."

Thus, the phrase, "regardless of the nature of the work performed" was specifically deleted from the subsection. The effect of that deletion warrants a review of the history of the "corporate officer" statute. Erzen v. SAIF, 40 Or App 771, rev den 287 Or 507 (1979), summarizes that history.

In Erzen, the claimant was a corporate officer of a company that provided residential security. In addition to his corporate role, the claimant performed work as a manager and fill-in patrolman. He was injured while performing work as a patrolman. At the time of his injury, the claimant had not elected to obtain workers' compensation as a corporate officer. Upon filing a claim for his injury, the SAIF Corporation issued a denial on the ground that the claimant had failed to elect that coverage and was, therefore, not a subject worker. The claimant requested a hearing, and both the referee and the Board held that the claimant was entitled to compensation.

On appeal, the court noted that at the time of its decision, former ORS 656.027(7) expressly provided that officers of corporations who had not specifically elected coverage were nonsubject workers. It further noted, however, that prior to a 1966 interpretative order by the Workers' Compensation Board, the phrase "officer of a corporation" had not been defined. The Board interpreted a statute similar to former ORS 656.027(7) to exclude corporate officers from subject worker status only when they were injured during the performance of their duties as corporate officers, rather than as ordinary workers of the corporation. The Erzen court found the Board's interpretation to be consistent with the Legislature's intent to compensate workers injured in the course of their employment. 40 Or App at 776.

The Erzen court also found the Board's interpretative order to be consistent with an application of the "dual capacity doctrine" set forth in Carson v. SIAC, 152 Or 455 (1936). In enunciating that doctrine, the Carson Court noted that in the absence of a contrary statute, an officer of a corporation at the time of his or her injury may be compensated so long as at the time of the injury, he or she was performing labor as an ordinary worker. Thus, under the doctrine, it is the nature of the work, rather than the title of the individual, which controls. Carson, 152 Or at 458.

Following the Erzen decision, the 1981 Legislature amended ORS 656.027 to add subsection (8), which defined nonsubject corporate officers as those corporate directors who had substantial ownership interests in their corporations, "regardless of the nature of the work performed by such officer." Or Laws 1981, c. 535, Sec. 3. (Emphasis added). Thus, following the 1981 amendment, all corporate officers, including those injured in the course of ordinary work for their corporations, were deemed nonsubject.

As previously noted, however, the 1990 Legislature amended ORS 656.027 once again, this time specifically removing the phrase "regardless of the nature of the work performed . . ." We conclude that the removal of this phrase effectively resurrected the "dual capacity doctrine." It also appears to have removed the "contrary" statutory provision noted by the Supreme Court in Carson, supra, that would preclude a corporate officer's being compensated for an injury occurring as a result of work performed as an ordinary worker.[1]

In the present case, we agree with the Referee that claimant developed carpal tunnel syndrome as a result of his work as a dentist. His condition did not arise as a result of his corporate officer duties. Under these circumstances, we conclude that the current ORS 656.027(9) does not apply. Claimant was, therefore, a subject worker at the time of his "injury." See ORS 656.027.[2]

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[1] Although we do not consider amended ORS 656.027(9) to be ambiguous, a review of the legislative history is supportive of our conclusion that the application of the statute was designed to be limited. The "dual capacity doctrine" was not expressly discussed. Nevertheless, the statute was amended to limit the ability of employers to establish a "sham operation" with all employees serving as corporate officers, thereby avoiding the payment of workers' compensation premiums. Testimony of Ross Dwinell, Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side A.

[2] Because ORS 656.027(9) does not apply and claimant is thereby not "defined as nonsubject worker," ORS 656.039 also does not apply.

SAIF argues that, even if the dual capacity doctrine exists, claimant is prohibited from acting in more than one capacity in his professional corporation by ORS 58.075(1). Under that statute, a professional corporation may be organized to render one type of professional service only and services ancillary thereto. However, because there is no contention that this professional corporation provided any service other than dentistry, we find SAIF's reliance on ORS 58.075(1) to be inapposite. Moreover, even if there was such evidence, we do not see how it would impact the subjectivity issue. Accordingly, we conclude that ORS 58.075(1) is not relevant to this dispute.

SAIF also argues that OAR 436-50-050(1), promulgated by the Director, precludes claimant from benefiting from the dual capacity doctrine, because the rule retains the operative language ("regardless of the nature of the work performed") which was deleted from the statute in 1990. However, because under amended ORS 656.027(9) a corporate officer's subject status does depend on his working capacity at the time of his injury, the rule which provides to the contrary is inconsistent with the statute. Under such circumstances, the statute controls and we give no effect to the rule. See Forney v. Western States Plywood, 66 Or App 155 (1983); Walden J. Beebe, 43 Van Natta 2430 (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 $1,000, to be paid by the SAIF Corporation. 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 June 12, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**LEONARD E. MORRELL, Claimant**
WCB Case No. 91-17149
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Schultz's order that affirmed a Director's order denying vocational assistance. On review, the issue is whether the Referee was correct in affirming the Director's order finding that claimant is not eligible for vocational assistance. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

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

While noting that claimant was unable to continue to perform the regular work to which he was released, the record indicates that he was able to perform modified work at the employer. If a worker is able to return to his previous employment or to any other available and suitable employment with the employer at the time of injury, he is not eligible for vocational assistance. See ORS 656.340(6)(a); OAR 436-120-040(3)(a). The Director relied on the Rehabilitation and Review Section (RRS) for investigation and finding of facts. The RRS was aware of the facts that claimant was both released to regular work and that he was performing modified work with the employer at the time of injury. The

Director applied OAR 436-120-040(3)(a) and concluded that there was no basis for eligibility when a worker receives a regular work release. The Director's reliance on one of these facts (regular work release) rather than the other (return to modified work) is not an abuse of discretion. See Colclasure v. Wash. County School Dist. No. 48-J, 117 Or App 131, 132 (1992).

ORDER

The Referee's order dated March 9, 1992 is affirmed.

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In the Matter of the Compensation of
**MORRIS W. SALTEKOFF, Claimant**
Own Motion No. 91-0141M
SECOND RECONSIDERATION OF OWN MOTION ORDER OF DISMISSAL
Martin McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's November 18, 1992 Own Motion Order of Dismissal and our January 7, 1993 Own Motion Order on Reconsideration that dismissed as untimely claimant's request for Board review of the SAIF Corporation's September 4, 1992 Notice of Closure. Specifically, claimant contends that OAR 438-12-060(1), which requires that the request for Board review be in writing, is invalid and his October 1992 telephone call to the Board's Own Motion Specialist established a timely request for review of SAIF's Notice of Closure. In the alternative, claimant contends that he has established good cause for his untimely request for review.

On February 8, 1993, we abated and withdrew our January 7, 1993 order for reconsideration and allowed SAIF an opportunity to respond. After receiving SAIF's response, and further considering the matter, we issue the following order.

Claimant argues that OAR 438-12-060(1) is invalid because it exceeds the Board's statutory authority. Claimant bases this argument on his contention that OAR 438-12-060(1), which requires that a request for Board review of a Notice of Closure be in writing, is in conflict with OAR 438-12-055(1), which provides the appeal rights that an insurer must include in its Notice of Closure. Claimant argues that the appeal rights required by OAR 438-12-055(1) do not require that the request for review be in writing and that that rule should prevail over the allegedly conflicting OAR 438-12-060(1). On that basis, claimant argues that his October 1992 telephone call to the Own Motion Specialist is a timely request for review.

OAR 438-12-055(1) provides that the insurer's Notice of Closure shall include the following appeal rights:

> "IF YOU THINK THIS CLAIM CLOSURE IS WRONG, YOU MAY ASK THE WORKERS' COMPENSATION BOARD TO REVIEW IT AND DECIDE WHETHER YOU ARE ENTITLED TO MORE COMPENSATION. YOU MUST ASK FOR A REVIEW WITHIN 60 DAYS OF THE DATE OF THIS NOTICE OR YOUR RIGHTS TO CONTEST THIS NOTICE WILL BE LOST. YOU MAY ASK FOR A REVIEW BY WRITING TO THE BOARD AT 480 CHURCH STREET, S.E., SALEM, OREGON 97310. YOU MAY HAVE AN ATTORNEY OF YOUR CHOICE, WHOSE FEE WILL BE LIMITED TO A PERCENTAGE OF ANY MORE COMPENSATION YOU MAY BE AWARDED." (Emphasis added).

Claimant argues that the emphasized language indicates that it is permissible, but not required, to request review in writing. We disagree with that interpretation. Claimant is not required to request review, it is his option. However, if he chooses to request review, his request is to be in writing. In addition, the appeal rights indicate only one method to request review and that method is in writing. Therefore, we do not agree that OAR 438-12-055(1) permits a request for review in any form other than in writing. Furthermore, OAR 438-12-060(1) provides, in pertinent part, that the "request for a review

shall be in writing. . . ." Therefore, the two rules are not in conflict and claimant's October 1992 telephone call does not satisfy the requirements of a request for review.

In the alternative, claimant argues that he has established "good cause" for his failure to request review within 60 days of the claim closure. We disagree.

The September 4, 1992 Notice of Closure was received in claimant's attorney's office on September 5, 1992. The legal assistant docketed the Notice for Reconsideration to be filed no later than November 3, 1992 and gave the file and notice to the attorney working on claimant's case on September 8, 1992. This attorney subsequently quit and claimant's case was assigned to his current attorney. On or about October 5, 1992, claimant's current attorney dictated a request for review of the claim closure. For some reason, possibly due to problems with the dictation equipment, this request for review was never transcribed. At the same time, claimant's attorney dictated a letter requesting additional information from Dr. Johnson, claimant's treating physician. That letter was transcribed and claimant's attorney received Dr. Johnson's response on October 15, 1992. Sometime prior to November 4, 1992, claimant's attorney dictated a letter to the Board submitting Dr. Johnson's response. That letter was received by the Board on November 6, 1992 and construed as an untimely request for review.

While the neglect of an attorney's employee who is not responsible for handling requests for review may be excusable neglect, see Brown v. EBI Companies, 289 Or 455, 460 (1980), neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. See Sekermestrovich v. SAIF, 280 Or 723 (1977); EBI Companies v. Lorence, 72 Or App 75, rev den 299 Or 118 (1985).

Claimant's attorney argues that the untimely request resulted from the negligence of his typist, who did not understand the urgency and importance of the transmittal of Dr. Johnson's response to the Board. Citing Brown v. EBI Companies, supra, claimant's attorney argues that the typist's neglect is excusable because the typist is not responsible for processing requests for review.

We disagree and find that EBI Companies v. Lorence, supra, is dispositive on the facts of this case. In Lorence, the attorney dictated a hearing request and gave it, along with other dictation, to his secretary. The hearing request was apparently never transcribed. When the attorney later reviewed the claimant's file, he discovered that no hearing request had been filed. He then filed a request for hearing 18 days past the 60-day time limit. Lorence, supra at 72 Or App 77. The court held that "it was the negligence of the attorney in failing to keep track of the preparation of the request for hearing and to make sure that it was filed on time that caused the late request." Lorence, supra at 72 Or App 78. The court also held that nothing under the facts of the case could be held to be excusable neglect if it were done by the claimant himself. Therefore, the court concluded that the claimant failed to establish good cause for his untimely hearing request. Id.

The same reasoning applies here. The typist may have been negligent in failing to transcribe the dictation promptly. However, the failure of the typist cannot excuse the primary failure of the attorney, who was aware of the exact date on which the request for review had to be filed and merely failed to follow through. Id. Accordingly, we continue to find that claimant has failed to establish good cause for his failure to timely request review of the claim closure. Therefore, we adhere to our prior order which dismissed claimant's request for review of the Notice of Closure.

Accordingly, as supplemented herein, we adhere to and republish our prior orders. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**MICHELE M. WALKER-WYATT, Claimant**
WCB Case No. 90-20461
ORDER ON REVIEW (REMANDING)
Francesconi & Busch, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Barber's order that dismissed her hearing request for lack of jurisdiction. Claimant contends that: (1) the Hearings Division has jurisdiction to consider whether palliative care should have been provided for her compensable injury; and (2) this matter should be remanded for the taking of evidence. In its brief, the insurer moves to strike portions of claimant's appellant's brief that refer to exhibits not admitted into the record. On review, the issues are jurisdiction and, alternatively, remand and motion to strike. We vacate in part and affirm in part.

The Referee concluded that he did not have jurisdiction to consider claimant's request for palliative care, finding that such jurisdiction lies exclusively with the Director pursuant to ORS 656.245(1)(b). See also ORS 656.704(3). We disagree.

ORS 656.245(1)(b), which took effect on July 1, 1990, provides in relevant part:

> "If the worker's attending physician * * * 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."

We have relied on this provision to hold that the Director, not the Hearings Division, has original jurisdiction to consider requests for palliative care. Robert D. Cox, 43 Van Natta 2726 (1991).

Based on our reading of ORS 656.245(1)(b), we find two conditions precedent to the Director's jurisdiction: (1) claimant's attending physician requests prior approval for palliative care from the insurer; and (2) such approval is not granted by the insurer. Only after both conditions are satisfied does the Director have jurisdiction to consider a palliative care request under the statute.

Claimant's counsel represented at hearing that the disputed medical services were provided beginning in June 1990. (Tr. 2). Thus, some of those services were provided prior to the effective date of ORS 656.245(1)(b). Under the law in effect prior to July 1, 1990, there was no requirement for prior authorization of palliative care.

In Ida M. Walker, 43 Van Natta 1402 (1991), the claimant received palliative chiropractic treatment in 1989 for a compensable injury that occurred in 1969. She filed a claim for that treatment, which was denied by the employer. She requested a hearing from the denial. In her Opinion and Order, the Referee held that although claimant's treatment was both reasonable and necessary as a result of her 1969 compensable injury, it was not compensable under the then newly-amended ORS 656.245. We reversed, concluding that the legislature did not intend the new law to be applied retroactively when such construction would produce an absurd or unjust result and would clearly be inconsistent with the purposes and policies of the Workers' Compensation Law. We, therefore, held that palliative services which would have otherwise been compensable at the time they were rendered did not become noncompensable by virtue of the amendment to ORS 656.245. 43 Van Natta at 1407.

We find Walker to control the present case. As previously noted, a portion of the treatment claimant seeks to have declared compensable was rendered prior to the July 1, 1990 effective date of the amendments to Chapter 656. As in Walker, it would be unfair to require the present claimant's attending physician to seek pre-authorization pursuant to a law not yet in effect at the time the treatment was provided. Such a requirement would be unreasonable and would result in prejudice to claimant. Accordingly, we conclude that the 1990 amendment to ORS 656.245 does not apply to the medical services provided to claimant prior to July 1, 1990.

Under the law in effect prior to July 1, 1990, claimant was entitled to medical services, whether palliative or not, that are reasonably and necessarily incurred in the treatment of the compensable injury. Former ORS 656.245(1); West v. SAIF, 74 Or App 317, 320-21 (1985); Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). Claimant had the burden of proving that treatment is reasonable and necessary. McGarry v. SAIF, 24 Or App 883, 888 (1976). Medical treatment disputes generally were within the jurisdiction of the Board and Hearings Division. See ORS 656.283(1).

Because the Referee dismissed claimant's hearing request and did not receive any evidence into the record, we find that the record is insufficiently developed for our review of the reasonableness and necessity of treatment provided before July 1, 1990. Therefore, we remand this matter to the Referee to take evidence and make findings and conclusions regarding the reasonableness and necessity of palliative care provided before July 1, 1990. See ORS 656.295(5). The Referee may conduct the hearing in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order resolving this issue.

We turn to the issue of the Referee's jurisdiction to review the appropriateness of palliative care provided on or after July 1, 1990. At hearing, claimant contended that the insurer failed to respond to his attending physician's palliative care request within 30 days, thereby presenting a claim processing issue within the Hearings Division's jurisdiction under ORS 656.283(1). (Tr. 2-4). Claimant relied on former OAR 436-10-041(4), which provided that if the attending physician did not receive written notice from the insurer within 30 days disapproving a palliative care request, such a request "shall be approved." However, the 30-day rule in former OAR 436-10-041(4) did not become effective until December 26, 1990. See WCD Admin. Order 32-1990.

In any event, regardless of the merit of claimant's contention, the fact remains that, as of the hearing date, a dispute continued to exist regarding the request for palliative care. Only the Director has jurisdiction to resolve that dispute. See Dennis L. Russell, 45 Van Natta 126 (1993); Rexi L. Nicholson, 44 Van Natta 1546 (1992); Gladys M. Theodore, 44 Van Natta 905 (1992). That is, whether the insurer would be deemed to have approved the treatment request under the former rule is a question within the province of the Director, not this forum. Dennis L. Russell, supra.

Claimant also contended at hearing that the insurer failed to give her prior written notification of the changes in medical treatment requirements and procedures resulting from the 1990 Act. (Tr. 2). See former OAR 436-10-041(5) (WCD Admin. Order 6-1990). See also Department of Insurance and Finance Bulletin No. 215, issued June 8, 1990; claimant contended that, until such notification was made, all palliative treatment is deemed compensable. As we reasoned above, however, inasmuch as there is a dispute concerning unpaid palliative care, subsequent to July 1, 1990 the Director has exclusive jurisdiction to consider it. See Dennis L. Russell, supra. The merits of claimant's contention can then be addressed by the Director.

## ORDER

The Referee's order dated November 4, 1991 is vacated in part and affirmed in part. That portion of the Referee's order that dismissed claimant's hearing request insofar as it addressed palliative treatment provided before July 1, 1990, is vacated. That portion of claimant's hearing request is reinstated, and the issue of the reasonableness and necessity of such treatment is remanded to Referee Barber for further proceedings consistent with this order. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**NANNETTE L. WHITE-GOINGS, Claimant**
WCB Case No. 91-14671
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Davis' order that found that her claim was not prematurely closed. On review, the issue is claimant's medically stationary date. We modify.

## FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

## CONCLUSIONS OF LAW AND OPINION

The Referee and the parties have analyzed this matter as a premature closure case. A premature closure case turns on the issue of whether or not claimant's condition was medically stationary on the date of claim closure. See Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). In this case, however, claimant does not contend that she was not medically stationary when the February 28, 1991 Determination Order closed her claim. Rather, she contends that she became medically stationary in October 1990, not the July 31, 1990 date listed on the Determination Order. (Tr. 2). She seeks to modify the Determination Order's medically stationary date. We agree and modify the Determination Order accordingly.

A Determination Order determines claimant's substantive entitlement to temporary disability benefits for a compensable claim. See generally ORS 656.268. Claimant's substantive entitlement to temporary disability benefits ends on the medically stationary date. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question which must be decided on the basis of competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981).

Here, the February 28, 1991 Determination Order declared claimant medically stationary as of July 31, 1990, and terminated temporary disability benefits as of that date. (Ex. 32). That determination was apparently based on the report of Dr. Erickson, claimant's treating physician, who declared claimant medically stationary and released her for regular work on July 31, 1990. (Ex. 23). However, Dr. Erickson later wrote in May 1991 that "[claimant] was not medically stationary until October of 1990. At that time, she was placed in the permanent light duty position." (Ex. 36).

The balance of the record supports Dr. Erickson's change of opinion. Claimant returned to regular work following the work release on July 31, 1990, but after five work days, she returned to Dr. Erickson with complaints of increasing back pain and spasms. (Ex. 24). Dr. Erickson diagnosed overuse tendinitis/myositis, prescribed pain medication, and restricted claimant to light sedentary work. (Ex. 25). Claimant returned to Dr. Erickson on September 5, 1990, for a refill of her prescription, noting that the medication was controlling her back pain. (Ex. 25A).

Claimant testified that her condition progressively improved between July 31, 1990 and her return to light duty work in October 1990. (See Tr. 16, 22-25). Her testimony is supported by the independent medical examination report of Drs. Barth and Coletti. During their examination on September 26, 1990, they noted no physical complaints, other than mild tenderness to palpation of the rhomboid muscles. (Ex. 27).

Based on the record as a whole, we are most persuaded by Dr. Erickson's May 16, 1991 opinion that claimant did not become medically stationary until she returned to light duty work. She returned to light duty work on October 18, 1990. (See Ex. 28A). Therefore, we modify the Determination Order to declare that claimant became medically stationary on October 18, 1990, and to award temporary disability benefits through that date.

ORDER

The Referee's order dated April 7, 1992 is modified in part and affirmed in part. The February 28, 1991 Determination Order is modified to declare claimant medically stationary as of October 18, 1990, and to award temporary disability benefits through that date. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 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 Referee's order is affirmed.

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In the Matter of the Compensation of
**GEORGE E. GATCHET, Claimant**
Own Motion No. 93-0099M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right foot injury. SAIF contends that claimant's claim is subject to the Board's own motion authority because his aggravation rights have expired. We disagree and dismiss for lack of own motion jurisdiction.

We have own motion jurisdiction of claimant's claim only if his aggravation rights under ORS 656.273 have expired. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). ORS 656.273(4) provides:

> "(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.
>
> "(b) 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.

SAIF contends that claimant's aggravation rights expired on August 19, 1990, five years from the date of his injury. SAIF apparently reasons that claimant's aggravation rights are governed by ORS 656.273(4)(b). We disagree. ORS 656.273(4)(b) applies only to accepted injuries. That is, an injury is not in a nondisabling status unless and until it is accepted and classified as nondisabling. Thomas L. Runft, 43 Van Natta 69 (1991). Here, SAIF did not accept claimant's claim until December 19, 1985. The claim was then classified as nondisabling. As evidenced by a letter dated November 3, 1986 from the Department to SAIF, claimant requested reclassification of his claim within a year from the date it was accepted as being in a nondisabling status. Thereafter, by Determination Order dated January 9, 1987, the Department ordered the claim reclassified as disabling. SAIF did not appeal that order. Because claimant requested reclassification within one year from the date his claim was accepted as nondisabling and the Department subsequently reclassified the claim, we do not find ORS 656.273(4)(b) applicable. See Thomas L. Runft, supra; see also Robert E. Wolford, 45 Van Natta 435 (1993).

Instead, claimant's aggravation rights are governed by ORS 656.273(4)(a). Under that subsection, claimant's aggravation rights expire five years after the first determination order or notice of closure made under ORS 656.268. Here, the first Determination Order issued under ORS 656.268 on January 11, 1988. Therefore, claimant had until January 11, 1993 to file an aggravation claim. By letter dated December 16, 1992, Dr. Lisle, treating podiatrist, requested that claimant's claim be reopened for surgery. On its Own Motion Recommendation form dated February 4, 1993, SAIF stated that claimant's request for reopening was received on December 21, 1992.

Inasmuch as claimant filed an aggravation claim prior to the expiration of his aggravation rights, we conclude that we lack own motion jurisdiction to consider claimant's current request for claim reopening and temporary disability benefits. Accordingly, claimant's request for own motion relief is dismissed. Instead, SAIF should process claimant's request as a claim for aggravation under ORS 656.273.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARK A. PENDELL, Claimant**
WCB Case No. 91-13051
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of Referee Hazelett's order which: (1) set aside an Order on Reconsideration on the ground that it was invalidly issued; (2) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD); and (3) dismissed claimant's hearing request. On review, the issue is validity of the WCD's Order on Reconsideration. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On April 21, 1991, claimant requested reconsideration of the Determination Order. His request for reconsideration was made on the form provided by the Department of Insurance and Finance. On the form, claimant checked the box indicating that he disagreed with the impairment findings made by his attending physician at the time of claim closure. With his request for reconsideration, claimant submitted a supplemental report from his attending physician.

On August 29, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all aspects. The order acknowledged that claimant was entitled to a medical arbiter as there was a dispute over the impairment findings. However, the order explained that the Director was required by a circuit court judge's injunction to issue a reconsideration order "regardless of whether the reconsideration process had been completed."

By a letter dated October 28, 1991, the Appellate Unit of WCD informed claimant that in accordance with his counsel's request, a medical arbiter had been selected to review the impairment findings used in rating his disability. In a letter dated November 6, 1991, claimant's counsel informed the Appellate Unit that claimant would not be attending the medical arbiter examination due to the amount of time which elapsed between claimant's request for reconsideration and the scheduling of the arbiter's examination.

## CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning as set forth in the Referee's order with the following supplementation.

First, we note that the insurer moved to dismiss claimant's hearing request on the ground that the Order on Reconsideration was invalid because no medical arbiter had been appointed. (Tr. 4-5). Subsequent to the Referee's order, we held that only the party objecting to the Determination Order or Notice of Closure has the right to enforce the statutory requirement for appointment of a medical arbiter. Randy M. Mitchell, 44 Van Natta 2304 (1992). In other words, the party who did not object to the Determination Order or Notice of Closure may not use the statute defensively to have an Order on Reconsideration declared invalid for failure to appoint a medical arbiter. Id. Since the insurer did not object to the Determination Order in this case, it may not move to dismiss claimant's request for review on the basis that the Order on Reconsideration is invalid because no medical arbiter was appointed.

However, whether a party objects to the attending physician's impairment findings, so that appointment of a medical arbiter is required, is a question of fact. Dale A. Pritchett, 44 Van Natta 2134 (1992).

Here, claimant's request for reconsideration indicated that he disagreed with the impairment findings of the attending physician that were used to rate his permanent disability. At hearing, claimant's counsel indicated that there was no dispute with the impairment findings of the attending physician, provided that a supplemental medical report from Dr. Lee was considered. Nonetheless, the fact remains that claimant did dispute the impairment finding used in the Determination Order to rate

the extent of his permanent disability. Finally, claimant did not specifically waive his right to a medical arbiter. See Brenton R. Kusch, 44 Van Natta 2222 (1992). Accordingly, we agree with the Referee that the Order on Reconsideration was invalid. See Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992).

ORDER

The Referee's order dated May 6, 1992, as reconsidered May 14, 1992, is affirmed.

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March 16, 1993 Cite as 45 Van Natta 487 (1993)

In the Matter of the Compensation of
**KHAMPENG THAMMASOUK, Claimant**
WCB Case No. 91-17533
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband and Brazeau.

The insurer requests review of Referee Daughtry's order that directed the insurer to calculate claimant's rate of temporary disability benefits based on a five-day 40-hour work week. On review, the issue is rate of temporary disability.

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

As noted by the Referee, this case is controlled by former OAR 436-60-025(4)(a), which provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

Like the Referee, we conclude that claimant was employed for "less than four weeks" at the time of his injury. Although he had previously been employed by Kelly Services, his status as a full-time student dictated that with the beginning of each school year, he effectively terminated his employment with Kelly and renewed it at the beginning of each successive summer. Thus, at the time of his injury in 1991, claimant had been on his "new" job fewer than four weeks.

Because claimant had been employed fewer than four weeks at the time of his injury, former OAR 436-60-025(4)(a) required that the insurer use the intent of the employer and the worker at the time of hire in calculating the rate of compensation. From this record, we conclude that it was the intent of claimant's employer, Kelly Services, to allow the Secretary of State's office, claimant's actual worksite, to negotiate claimant's work hours. We further conclude, as did the Referee, that claimant and the Secretary of State's office agreed that claimant would be employed 40 hours per week during his summer tenure. It is, therefore, this 40-hour-per-week schedule upon which the insurer was required to calculate claimant's rate of compensation.

Because the insurer requested review and we have concluded that claimant's compensation should not be disallowed or reduced, claimant is entitled to a reasonable 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 attorney fee for claimant's attorney's services on review is $800, 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

In the Matter of the Compensation of
**GLEN D. ROLES, Deceased, Claimant**
WCB Case Nos. 88-19267, 89-06314, 89-14455 & 90-02445
SECOND ORDER ON REMAND
Welch, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our February 18, 1993 Order on Remand which: (1) directed SAIF to pay temporary disability granted by an earlier referee's order; and (2) assessed penalties and attorney fees under former ORS 656.262(10) and 656.382 for unreasonable claim processing. Asserting that SAIF may direct its objections to the court, claimant opposes SAIF's motion.

SAIF raises several issues in its motion, most of which have previously been considered and addressed in our prior order. We shall not further respond to arguments which have already been presented. Nevertheless, we will reply to new contentions raised by SAIF in response to our order.

Referring to our prior decisions which found that SAIF was not obligated to pay claimant's temporary disability award, SAIF asserts that it is "absurd" for us to now hold that its conduct was unreasonable. See Glen D. Roles, 43 Van Natta 278 (1991); Glen D. Roles, 43 Van Natta 379 (1991). We disagree.

To begin, since our prior decisions have been reversed and all cases remanded for reconsideration, our order on remand is now the sole decision from this forum regarding this dispute. Thus, our remand order must rise or fall on its own reasoning, irrespective of any since withdrawn, reversed, or reconsidered decisions.

In any event, as we noted in our prior order, our previous conclusion that SAIF was not unreasonable in failing to pay the temporary disability award pending appeal was premised on our erroneous belief that the earlier referee lacked authority to award temporary disability. (Likewise, we previously reasoned that the award could not constitute "compensation" which would be payable pending appeal under former ORS 656.313.)

Yet, as we discussed in our order on remand, the court has dispelled this "lack of authority" theory. With the rejection of that theory, SAIF's defense for its refusal to comply with the clear and unambiguous directives of an earlier referee's order (as well as subsequent orders re-enforcing that decision) can essentially be described as follows: the earlier referee's order was so blatantly wrong that SAIF was not unreasonable in failing to follow it. We continue to consider such a position insufficient to constitute a legitimate doubt regarding SAIF's claim processing responsibility.[1]

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[1] We recognize that our earlier decision which did not find SAIF's conduct to be unreasonable relied on Wacker Siltronic v. Satcher, 103 Or App 513 (1990). However, on reconsideration, we do not find Satcher to be helpful in evaluating whether SAIF was justified in withholding claimant's temporary disability award pending appeal. We reach such a conclusion because Satcher involved withheld medical services granted by an unappealed referee's order during an appeal of an earlier compensability decision. Thus, in Satcher, the carrier's noncompliance with a referee's order was based on the express exclusion of "medical services" from the definition of "compensation" which was required to be paid pending appeal under former ORS 656.313(4). Here, no such statutory exclusion (expressed or otherwise) existed to justify SAIF's refusal to pay the referee's temporary disability award pending its appeal.

We further acknowledge our prior reliance on Georgia-Pacific v. Hughes, 305 Or 286 (1988), for the proposition that since the temporary disability benefits granted by the earlier referee's order never became due (as a result of our subsequent reversal of that order on its merits), a penalty was not warranted. Nevertheless, on reconsideration, we find Hughes distinguishable because that decision pertained to the payment of interim compensation awarded by an appealed referee's order pursuant to a subsequently reversed Court of Appeals decision. Here, in contrast, the temporary disability granted by the appealed earlier

Characterizing its sole disputed conduct as its initial failure to comply with Referee Michael Johnson's temporary disability award, SAIF objects to the Board's assessment of several 25 percent penalties for that same conduct. We disagree with SAIF's characterization of our penalty assessment. Nevertheless, after further reflection, we conclude that one of our assessments was not warranted.

Our decision to assess multiple penalties was premised on the existence of a separate and distinct act of defiance by SAIF; specifically, SAIF's refusal to pay Referee Michael Johnson's temporary disability award as directed by a subsequent litigation order (whether that order was a referee's order or a Board decision). A brief summary of the procedural background will illustrate our reasoning.

Following SAIF's failure to comply with Referee Michael Johnson's order, claimant requested a hearing. Referee Harri directed SAIF to comply with the "Johnson" order and assessed penalties and attorney fees. When SAIF failed to comply with the "Harri" order, claimant requested another hearing. Referee Emerson assessed penalties and attorney fees for SAIF's failure to comply with the "Harri" order. (Emerson did not direct SAIF to comply with the prior litigation orders.) Thereafter, claimant requested another hearing. Referee Podnar declined to assess additional penalties and attorney fees. Claimant requested another hearing. Prior to that proceeding, the Board had reversed the "Johnson" order, but affirmed that portion of the "Harri" order which directed SAIF to comply with the "Johnson" order. Thereafter, Referee Peterson declined to assess penalties and attorney fees for SAIF's noncompliance with the Board's "Harri" order.

This illustration establishes that there were three separate acts of noncompliance with referee/Board directives. The first defiant act was SAIF's failure to comply with Referee Johnson's order. (The "Harri" proceeding.) The second unreasonable act was SAIF's refusal to comply with Referee Harri's order enforcing Referee Johnson's order. (The "Emerson" proceeding.) The third violation was SAIF's failure to follow the Board's order affirming that portion of Referee Harri's order which had directed SAIF to comply with Referee Johnson's order. (The "Peterson" proceeding.)

Omitted from mention as a proceeding involving a separate and distinct act of noncompliance was the "Podnar" proceeding. Inasmuch as the referee's order (Emerson) prior to the "Podnar" proceeding did not direct SAIF to comply with the previous referee decisions (but rather only assessed penalties and attorney fees), the conduct at issue before Referee Podnar (SAIF's failure to comply with Referee Harri's directive to pay Referee Johnson's temporary disability award) was the same conduct at issue before Referee Emerson. Under such circumstances, we do not consider it appropriate to assess SAIF a second penalty and related attorney fee for the identical conduct. Thus, that portion of our prior order which assessed a 25 percent penalty and a $750 penalty-related attorney fee as a result of the "Podnar" proceeding is withdrawn.

Such reasoning does not apply to our conclusion regarding the "Peterson" proceeding. The referee prior to the "Peterson" proceeding (Podnar) had not directed SAIF to comply with the previous referee decisions. Nevertheless, at the time of the "Peterson" proceeding, the Board had issued an order affirming that portion of Referee Harri's order directing SAIF to comply with Referee Johnson's order. Consequently, the proceeding before Referee Peterson did involve a separate and distinct act of noncompliance with a litigation order; i.e., the Board's affirmation of the Referee Harri directive.

Accordingly, we continue to conclude that separate penalties and related attorney fees for such separate and distinct unreasonable conduct is justified. However, instead of four unreasonable acts as found in our prior order, we find three separate and distinct instances of unreasonable conduct.

The remaining arguments advanced by SAIF have already been considered and answered in our prior order. Therefore, such contentions shall not be further entertained by this forum. In reaching this conclusion, we acknowledge SAIF's admonition that "[u]nless corrected or convincingly explained, [the Board's serious legal] errors will require another appeal in this case." Notwithstanding SAIF's concerns, we are confident that we have completed our review and rendered our decision in a manner consistent both procedurally and substantively with our statutory obligations. As with any of our decisions, a party is entitled to seek judicial review should that party disagree with our opinion.

Finally, we conclude that claimant's counsel is entitled to an additional attorney fee for services rendered in responding to SAIF's motion for reconsideration. 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 for claimant's attorney's services on reconsideration insofar as those services pertain to the temporary disability issue is $150, to be paid by SAIF. This award is in addition to the attorney fee awards granted by our prior order. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response), the complexity of the issue and the value of the interest involved.

Accordingly, we withdraw our February 18, 1993 order. On reconsideration, as modified and supplemented herein, we adhere to our February 18, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GLEN D. ROLES, Deceased, Claimant**
WCB Case No. 90-18683
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our February 18, 1993 order which assessed a penalty under amended ORS 656.262(10) for SAIF's failure to pay temporary disability granted by prior litigation orders. SAIF's motion has been submitted in conjunction with its motion for reconsideration of our February 18, 1993 Order on Remand which also involved these parties, as well as similar issues. Contending that SAIF can direct its objections to the court, claimant opposes SAIF's motion.

Most of SAIF's arguments have been considered in our Second Order on Remand. Glen D. Roles, 45 Van Natta 488 (1993). Since SAIF's contentions have already been addressed, we shall not repeat our response in this order. However, we incorporate our second remand order by this reference.

After further consideration of this current dispute, we nevertheless conclude that a penalty is not warranted. We reach such a conclusion because this proceeding before Referee T. Lavere Johnson did not involve a separate and distinct act of noncompliance with a litigation order.

As we discussed in our second remand order, our penalty assessments were based on separate acts of noncompliance with referee/Board directives. Those acts were as follows: (1) SAIF's failure to comply with Referee Michael Johnson's order (the "Harri" proceeding); (2) SAIF's refusal to comply with Referee Harri's order directing SAIF to follow Referee Michael Johnson's order (the "Emerson" proceeding); and (3) SAIF's failure to comply with the Board's order affirming that portion of Referee Harri's "enforcement" order (the "Peterson" proceeding).

In making this determination, we declined to assess a penalty for SAIF's conduct following the "Emerson" order (which was reviewed in the "Podnar" proceeding). Inasmuch as Emerson's order had not directed SAIF to comply with the previous referee decisions (but rather only assessed penalties and attorney fees), we concluded that the conduct at issue before Referee Podnar (SAIF's failure to comply with Referee Harri's directive to pay Referee Johnson's temporary disability award) was the same conduct which had been at issue before Referee Emerson. Considering that we were evaluating the identical conduct which had been previously reviewed by Referee Emerson, we held that a separate penalty was not warranted as a result of the "Podnar" proceeding.

Here, at the time of the proceeding before Referee T. Lavere Johnson, the immediately prior referee's order had been Referee Peterson. At the time of the "Peterson" proceeding, the Board's affirmation of Referee Harri's "enforcement" order had issued. Since the Peterson order, no subsequent litigation order (from either a referee or the Board) enforcing a previous decision to pay Referee Michael Johnson's temporary disability award had issued.

Thus, at the time of this "T. Lavere Johnson" proceeding, there had been no separate and distinct act of defiance by SAIF. Rather, its conduct was identical to the conduct reviewed during the

"Peterson" proceeding. Moreover, circumstances had dramatically changed by the time of the "T. Lavere Johnson" proceeding. Specifically, the Board had issued reconsideration orders reversing Referee Harri's directive to comply with Referee Michael Johnson's temporary disability award.

In other words, by the time of this "T. Lavere Johnson" proceeding, no litigation order existed directing SAIF to comply with Referee Michael Johnson's temporary disability award. In light of such circumstances, we do not consider SAIF's conduct to have been unreasonable. See ORS 656.262(10). Consequently, we withdraw that portion of our order which assessed a penalty. Considering our conclusion that SAIF's conduct was not unreasonable, we decline to address SAIF's contention that amended ORS 656.313 is applicable to this dispute.

Finally, we continue to adhere to our prior holding that claimant is entitled to Referee Michael Johnson's temporary disability award. However, in doing so, we repeat that SAIF is obligated to pay that award only one time. Therefore, if SAIF pays the award pursuant to our remand order arising from one of the proceedings addressed in that order, it need not also pay that award pursuant to this order.

Accordingly, we withdraw our February 18, 1993 order. On reconsideration, as modified and supplemented herein, we adhere to our February 18, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DANNIE W. CRAWLEY, Claimant**
WCB Case No. 91-06851
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Spangler's order that granted claimant permanent total disability. In its brief, SAIF moves to vacate the order, due to the Referee's alleged lack of jurisdiction to review claimant's permanent disability. On review, the issues are jurisdiction and permanent total disability.

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

SAIF moves for dismissal, contending that the Referee lacked jurisdiction to review the October 1990 Determination Order because the claim is in Own Motion status. We deny the motion.

Claimant's entitlement to redetermination of permanent disability stems from the fact that the claim was voluntarily reopened for an Authorized Training Program under former ORS 656.268(5). See Clifford A. Bettin, 44 Van Natta 2455 (1992). Consequently, the Referee had authority to review the extent of claimant's permanent disability, even though claimant's aggravation rights had expired. See former ORS 656.268(6). Accordingly, SAIF's motion to dismiss on jurisdictional grounds is denied.

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 is $2,000, to be paid by the SAIF Corporation. 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated May 22, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $2,000, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**LLOYD G. CURRIE, Claimant**
WCB Case Nos. 91-00066 & 90-16647
ORDER ON REVIEW
Stephen V. Piucci, Claimant Attorney
Charles Lundeen, Defense Attorneys
Bullard, Korshoj, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Leahy's order which: (1) found that claimant's request for a hearing on Liberty's denial of November 26, 1990 was timely filed; (2) set aside its denials of November 26, 1990 and March 8, 1991, which alternatively denied compensability and/or responsibility for claimant's current low back condition; and (3) upheld the self-insured employer's denials of claimant's new injury and occupational disease claims for the same condition. In its respondent's brief, the self-insured employer seeks review of the Referee's $4,000 assessed attorney fee award. The issues on review are timeliness of the hearing request, compensability, responsibility, aggravation 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.

Since the last arrangement of compensation on December 13, 1989, claimant experienced a symptomatic worsening of his low back condition, which was established by medical evidence supported by objective findings and resulted in diminished earning capacity.

In the August 10, 1989 Stipulated Settlement, claimant and Liberty Northwest stipulated that the unscheduled permanent disability award anticipated future waxing and waning of claimant's symptoms.

Claimant's worsened condition was no more than a waxing of symptoms that was contemplated by the August 10, 1989 Stipulated Settlement.

## CONCLUSIONS OF LAW AND OPINION

Because the hearing in this matter was requested after May 1, 1990, and convened after July 1, 1990, this matter is governed by the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch 2, § 54.

### Timeliness

We adopt the Referee's "Opinion" on this issue, and also conclude that claimant's request for hearing on Liberty's denials was timely.

### Compensability

This case involves an accepted compensable low back injury while Liberty was on the risk, followed by an increase in disability after the employer became self-insured. In cases such as this, where Liberty and the employer denied both compensability and responsibility, the threshold issue is compensability. Brent N. Jacobson, 43 Van Natta 87 (1991).

We must first address whether claimant's condition is compensably related to the 1985 accepted injury with Liberty. Liberty accepted claimant's 1985 back injury as a contusion of the sacral and right gluteal areas. (Ex. 11). We find, however, that the injury combined with a preexisting degenerative osteoarthritis condition to cause or prolong claimant's later disability and need for treatment. Therefore, claimant must prove that the injury is the major contributing cause of his current disability and need for treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (December 30, 1992). In this regard, we find that the cause of claimant's current disability is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The record contains the opinions of three independent medical examiners, Dr. Podemski, neurologist, Dr. Marble, orthopedic surgeon, and Dr. Rosenbaum, neurosurgeon, and the opinion of Dr. Wymore, general practitioner and claimant's treating physician since 1985. Drs. Podemski and Marble diagnosed chronic recurrent lumbosacral strain and degenerative osteoarthritis. They opined that claimant's current symptoms were related to his preexisting degenerative condition that was caused by the aging process. (Ex. 71-4). Dr. Rosenbaum opined that claimant sustained a chronic lumbosacral strain as a result of his 1985 compensable injury and that the major cause of his current condition was this injury plus claimant's present work activity. (Ex. 83). Dr. Rosenbaum further opined that claimant's preexisting degenerative osteoarthritis was not the major contributing cause of his current condition. (Id.). Neither Drs. Podemski, Marble nor Dr. Rosenbaum addressed claimant's bulging disc condition.

Dr. Wymore concurred with Drs. Podemski, Marble and Rosenbaum. (Exs. 75, 77a). However, in his deposition testimony, Dr. Wymore clarified his opinion as to the causal relationship between claimant's current disability and his degenerative osteoarthritis condition, present work activities, disc bulge and the 1985 compensable injury. As to claimant's preexisting degenerative condition, Dr. Wymore opined that it was asymptomatic prior to the 1985 injury and that the injury made the degenerative condition symptomatic. (Ex. 85-6, 85-7). Dr. Wymore stated that the injury also caused claimant's disc to bulge by weakening the joint capsule which holds the disc in place. (Ex. 85-10). But, he explained that, based on claimant's myelogram, the bulge was not responsible for claimant's current condition because it was not encroaching on claimant's spinal canal and claimant's pain was not radicular, as it would have been if the disc was responsible. (Ex. 85-11). Finally, Dr. Wymore opined that, while claimant's ongoing work activities for the employer made some contribution to his present symptomatology, claimant's compensable 1985 injury was the major contributing cause of claimant's current disability and need for treatment. (Ex. 85-24, 85-25).

When the medical evidence is divided, we tend to give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to Dr. Wymore's opinion. Dr. Wymore has been claimant's treating physician since his 1985 injury and is, therefore, in a better position to render an opinion on the cause of claimant's current disability. See Givens v. SAIF, 61 Or App 490 (1983). Dr. Wymore's opinion is also better reasoned because it addresses the causal connection between claimant's current disability and his preexisting condition, present work activities, disc bulge and the compensable injury. See Somers v. SAIF, 77 Or App 259, 262 (1986). Finally, Dr. Wymore's opinion is supported by the opinion of Dr. Rosenbaum.

Therefore, we conclude that claimant's 1985 work injury was the major contributing cause of his current low back condition which resulted in disability and need for medical treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra. Accordingly, the condition is compensable.

Responsibility

Relying on Spurlock v. International Paper Co., 89 Or App 461 (1988), and Linda L. Wise, 42 Van Natta 115 (1990), the Referee found that Liberty failed to prove that claimant's work activities after the employer became self-insured independently contributed to a pathological worsening of claimant's accepted condition. Therefore, he concluded that Liberty remained the responsible carrier. We agree that Liberty is responsible but rely on the following analysis.

ORS 656.308(1) provides:

> "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."

Under this statute, 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 or occupational disease during the subsequent work exposure. SAIF v. Drews, 117 Or App 596 (1993); Donald C. Moon, 43 Van Natta 2595 (1991); Ricardo

Vasquez, 43 Van Natta 1678 (1991). In this case, Liberty, as the last insurer with whom claimant had a compensable low back claim, remains presumptively responsible. In order to establish a new compensable injury, Liberty has the burden of proving that a work incident at claimant's subsequent employment was a material contributing cause of disability or need for treatment. See ORS 656.005(7); SAIF v. Drews, supra; Mark N. Wiedle, 43 Van Natta 855 (1991). In order to establish a new occupational disease, Liberty has the burden of establishing that subsequent work activities were the major contributing cause of a pathological worsening of the underlying compensable condition. See ORS 656.802(2); Randy L. Dare, 44 Van Natta 1868 (1992); Donald C. Moon, supra; Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991).

Again, we find this causation issue to be a complex medical question and rely on expert medical opinion for its resolution. See Uris v. Compensation Department, supra; Kassahn v. Publishers Paper Co., supra. There is insufficient medical evidence to establish either that an injurious work incident occurred or that subsequent work activities caused a pathological worsening of claimant's underlying condition. Dr. Rosenbaum opined that there was no incident or injury and that there was no pathological worsening of claimant's condition. (Ex. 72-4). Drs. Podemski and Marble found no evidence of objective change in claimant's condition. (Ex. 71-4). Finally, Dr. Wymore found no indication of an injury incident at work, and he agreed that there was no pathological worsening of the underlying condition. (Ex. 85-14, -16). After reviewing the aforementioned medical evidence, we do not find that claimant sustained a new injury or disease after the employer became self-insured. Accordingly, we conclude that Liberty remains responsible for claimant's current condition.

Aggravation

We next consider claimant's aggravation claim. An aggravation claim has two components: causation and worsening. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). Inasmuch as we have already addressed the causation component by concluding that claimant's current low back condition is a compensable consequence of the 1985 injury, we now determine whether claimant's condition has worsened.

In order to establish 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 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

It is also claimant's burden to prove that he has sustained a worsening of his compensable condition that is more than a waxing 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).

In the present case, claimant's low back condition was closed by Determination Order on December 13, 1989, which found claimant medically stationary on November 17, 1989 and awarded temporary total disability benefits, but no additional benefits for permanent disability. (Ex. 61a-1). Claimant had previously received benefits for 10 percent unscheduled permanent partial disability in a January 23, 1989 settlement stipulation. An August 10, 1989 Stipulated Settlement increased claimant's benefits for unscheduled permanent disability to 15 percent. (Exs. 51-2, 57b-1). In that same settlement, the parties stipulated that the award anticipated future waxing and waning of claimant's symptoms. (Ex. 57b-1).

Following the December 13, 1989 closure, claimant returned to work and worked at his regular job with few problems through December, January and February. (Tr. 32). However, his symptoms returned and, on July 24, 1990, Dr. Wymore took claimant off work due to severe back pain. (Tr. 32-33; Ex. 62, 67). Claimant returned to regular work on August 27, 1990. (Ex. 69). While neither Dr. Rosenbaum nor Drs. Podemski and Marble noted objective signs of worsening, they opined that claimant's subjective complaints had worsened. (Exs. 71-4, 72-4). Dr. Wymore opined that claimant's condition had worsened in that claimant has "more ongoing daily discomfort, more problems with more normal activities as opposed to only with strenuous activities." (Ex. 85-8). Moreover, he found that claimant's worsened condition was supported by objective findings, which included "tenderness over the lower lumbar and lower dorsal area with limitation of motion." (Ex. 85-21). Furthermore, claimant testified that his symptoms had increased in frequency since his 1985 injury. (Tr. 32, 46).

We find, based on this evidence, that claimant has established a symptomatic worsening of his low back condition. We also find that this worsening is supported by objective findings in the reports and testimony of Dr. Wymore. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Although claimant has established a worsening of his condition, because he has previously been awarded benefits for unscheduled permanent disability, he must also show that the worsening of his condition resulting in diminished earning capacity is more than a waxing of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Here, claimant's last award of benefits for unscheduled permanent disability was the August 10, 1989 Stipulated Settlement, which increased his disability award to 15 percent. At that time, the parties stipulated that the settlement anticipated future waxing and waning of claimant's symptoms. Moreover, as early as 1987, the medical reports show that it was anticipated that claimant's condition would wax and wane and it has done so since that time. In February 1987, Dr. Mason, claimant's then treating physician, opined that claimant "may have recurring bouts of discomfort." (Exs. 28). After claimant's first flare up, Dr. Mason again stated in September 1987 that "[h]e has had recurring bouts of symptoms and I anticipate that over the years that he will continue to have some problems with his back as long as he is doing a fairly physically active type of work." (Ex. 38). Further, Dr. Rosenbaum also predicted that claimant would have "exacerbations and remissions of his symptoms in the future associated with his work activity." (Ex. 57-3). Finally, during his deposition testimony, Dr. Wymore agreed that, since claimant's original injury, he has experienced numerous exacerbations and remissions. (Ex. 85-12, 85-13).

Under these circumstances, we find that claimant has not sustained his burden of proving that his worsening is more than a waxing of symptoms contemplated by the previous permanent disability award. Accordingly, we conclude that claimant has not met his burden of proving a compensable aggravation claim.

Attorney Fees

Although claimant did not prevail on the aggravation claim against Liberty, he partially prevailed over Liberty's denial to the extent that it denied the compensability of his current condition and need for treatment. Accordingly, claimant is entitled to an assessed attorney fee for services at hearing concerning the compensability issue and for services on review in defense of that issue.

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 issue is $3,700, to be paid by Liberty. This fee is in lieu of the Referee's $4,000 attorney fee award. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 15, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which set aside Liberty Northwest Insurance Corporation's aggravation denial is reversed. Liberty Northwest's aggravation denial is reinstated and upheld. In lieu of the Referee's $4,000 assessed attorney fee award, claimant's attorney is awarded an assessed attorney fee of $3,700 for services rendered at hearing and on review concerning the compensability issue, to be paid by Liberty Northwest. To the extent that Liberty Northwest denied the compensability of claimant's current low back condition, that portion of its denial shall remain set aside. The remainder of the order is affirmed.

**Board Member Hooton concurring and dissenting.**

This claim involves multiple issues for resolution, including compensability, responsibility, aggravation and attorney fees. I agree with the majority resolution of the issues of compensability and responsibility. I disagree with the resolution of the issues of aggravation and attorney fees. I write to clarify my disagreement on these issues.

The majority finds that claimant has experienced a symptomatic worsening of his condition, and a diminished earning capacity. I agree with that finding. The majority further finds, however, that the worsening is no more than waxing and waning, and thus find that claimant has failed to establish a claim for aggravation. It is this portion of the majority opinion with which I am unable to agree.

The majority correctly notes that a stipulated settlement entered in August of 1989 allows claimant an additional 5 percent unscheduled permanent partial disability and specifically states that the additional award is made in contemplation of waxing and waning. Despite that stipulation, that same settlement rescinded an April 1989 denial of an aggravation claim based on 14 days of temporary total disability, preceding the denial, with an additional 17 days of time loss in October, prior to closure. The insurer's acceptance in conjunction with the additional disability is explainable under the express terms of Gwynn v. SAIF, 304 Or 345 (1987), in which the Court established a period of 14 days as the maximum period to which the waxing and waning limitation could be applied. Consequently, the stipulation provides convincing evidence that the stipulation only considered waxing and waning of less than 14 consecutive days.

The majority examines the medical record and finds ample evidence of a history of a waxing and waning of symptoms related to the compensable condition. On the basis of this evidence, and the statements of at least one of claimant's treating physicians predicting ongoing periods of waxing and waning related to physical activity, the majority concludes that the claimant's current worsening is no more than the waxing and waning anticipated at the time of the last arrangement of compensation. This conclusion is based solely on the medical record and the anticipation of periods of symptomatic worsening by claimant's physician. However, this is not the question that must be resolved in deciding whether claimant's worsening presents a valid and compensable claim for aggravation.

ORS 656.273(8) provides that where claimant has received an award of permanent partial disability compensation, he must demonstrate that his worsened condition is more than the waxing and waning contemplated by that award. This statute acknowledges that it is possible to compensate a claimant for future disability in an award of permanent partial disability. When the award actually contemplates, and compensates claimant for, a loss of temporary earning capacity based on periodic symptomatic worsening, claimant would be doubly compensated if he also received temporary disability compensation for that period of temporary disability. On the other hand, it would be equally inappropriate to deny claimant temporary disability compensation if the period of temporary disability actually exceeded the period for which claimant was compensated in the award of permanent partial disability compensation.

Proving the length of any period of waxing and waning in an informal system that has historically avoided technical hurdles, both to compensation and to defenses, presents a difficult problem. The last award or arrangement of compensation may arise from a mutually acceptable stipulation of the parties, or, through a Notice of Closure or Determination Order. Unless the stipulation or order specifies a particular period of temporary disability that the award intends to compensate, the period of compensation appropriate for the award is very difficult to determine, and, where the award was made by the Department, the intention of the parties is an irrelevant question.

The Court met this problem in Gwynn by somewhat arbitrarily assigning a 14-day period as the maximum time period to which the waxing and waning limitation can apply. In addition, for periods of disability of less than 14 days the Court has traditionally focused on the waxing and waning contemplated by the medical evidence.

The legislature has recently returned the issue of the period of temporary disability contemplated by an award of permanent partial disability to a position of serious consideration by amending ORS 656.273 to provide that no specific period of disability or hospitalization is sufficient to establish a valid aggravation claim. ORS 656.273 (1)(a), (b). This amendment makes it possible to conclude that an award contemplated an unlimited period of temporary disability, and thus to deprive claimant of any aggravation claim based on a mere worsening of symptoms.

However, the focus of the statute remains the award of permanent partial disability. Where that award is based on the current standards for the rating of impairment, standards which permit no adjustment for fluctuating symptoms, the award cannot conceivably contemplate waxing and waning. See specially concurring opinion, Dana J. Fisher, 45 Van Natta 225 (1993). It is only where, as here, the parties have reached a stipulated settlement, that the question can now ever arise.

In Lucas v. Clark, 106 Or App 687 (1991), the court restated the criteria for proving the period for which waxing and waning was anticipated and compensated by the last arrangement of compensation through the medical evidence. The majority correctly states that test as "[i]f 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." 106 Or App at 690 (emphasis added). While the majority has stated the correct rule of law, they fail to apply it. The majority examines only the medical evidence, and does not look to whether there are indications in the record that the period of waxing and waning contemplated by the award of August, 1989 was intended to be limited to a specified period. I find that there is ample evidence in the stipulation that the parties contemplated only a period of waxing and waning of less than 14 days duration. This evidence, as noted above, derives from the fact that the very same stipulation which increased claimant's permanent partial disability also accepted an aggravation based on 14 days of temporary total disability. This period makes perfect sense, since, as a matter of law, at the time of the settlement, the parties could not contemplate waxing and waning of fourteen days or more.

In SAIF v. Bement, 109 Or App 387 (1991), the court reversed an award of permanent partial disability made by the Board solely to compensate claimant for future waxing and waning. It noted that the current standards do not permit the award, and that the court will not assume that the parties contemplated future waxing and waning where the parties could not contemplate future temporary disability as a matter of law. Id. at 390. Here, a similar form of reasoning supports the conclusion that the parties contemplated waxing and waning only for a period of fourteen days of temporary disability. At the time of the stipulation, Gwynn controlled the application of the waxing and waning limitation. Consequently, at the time of the stipulated settlement in this claim in August of 1989, the parties could not have contemplated waxing and waning of 14 days or longer as a matter of law.

By declining to recognize this limitation on the parties contemplations in 1989, the majority gives the insurer more than the benefit of its bargain, and deprives claimant of compensation for temporary disability for which he was not, and could not have been, compensated at the time of that settlement agreement. Claimant has experienced a worsening of symptoms resulting in temporary total disability of at least one month duration. I would find that that exceeds the worsening contemplated by the last arrangement of compensation even if it is within the period anticipated by claimant's physicians. I would therefore find claimant's aggravation claim compensable.

Finally, I disagree with the resolution of the attorney fee issue raised by the insurer. At hearing, the Referee permitted an assessed fee of $4,000. Liberty Northwest challenges that award as excessive. The majority allows a fee of $3,700 for services at hearing and on Board review, a decision which substantially reduces the fee allowed to claimant's attorney. The majority states that it has considered the factors in OAR 438-15-010(4), however, it provides no analysis of those factors to support the reduced award or to explain why it believed that the attorney fee awarded at hearing was excessive.

I find that claimant was presented with a serious and difficult challenge to compensability. Because of the change in the applicable law, claimant is required now to prove that a preexisting condition is not the major cause of his current need for treatment. Because this was not an issue requiring litigation at the time of claim acceptance, the extent and nature of the preexisiting condition in 1985 is difficult to establish. The Workers' Compensation Law has provided for relatively short statutes of limitation for the reporting of injuries, in acknowledgment of the fact that evidence easily disappears, memories become porous and a question that is easily susceptible of litigation immediately after an injury can become much more difficult with the passage of time. I would apply the same analysis to the litigation here, in which the claimant is, for the first time, required to examine the impact of a condition that was irrelevant in 1985, when the injury occurred.

I would also find that where there is a preexisiting condition that combines with an injury, the probability that claimant's attorney's services will go uncompensated is very high.

The services of claimant's attorney were also instrumental in assisting the claimant to retain the rights that accrue to an accepted claim. Despite the fact that the injury occurred some time ago, those rights remain substantial.

On the basis of this analysis, I would conclude that the Referee did not abuse his discretion in awarding a fee of $4,000 for services at hearing. I would also find claimant entitled to an additional $1,500 for services on Board review.

In the Matter of the Compensation of
**BRUCE C. DARR, Claimant**
WCB Case No. 91-03885
ORDER ON RECONSIDERATION (REMANDING)
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

It has come to our attention that our February 24, 1993 order, which vacated the Referee's dismissal order and remanded for further proceedings, did not address the applicability of Anton V. Mortensen, 42 Van Natta 1183 (1990). We now address it here.

Our prior order relied on Anton V. Mortensen, 40 Van Natta 1177, on recon 40 Van Natta 1702 (1988), in which the Board reviewed a Referee's order dismissing claimant's hearing request from a determination order as untimely filed. The Board held that the mailing of a determination order creates only a presumption that a claimant has received actual notice and that if the facts rebut that presumption, the statutory appeal period does not begin to run until the date of successful mailing or actual notice. Because the record in Mortensen was insufficiently developed for determining whether the presumption of successful mailing had been rebutted, the Board vacated the Referee's dismissal order and remanded for further proceedings.

Subsequently, on remand, the Referee again dismissed the claimant's hearing request as untimely. Finding that the determination order was mailed to the claimant's correct address on the date of issuance, the Referee concluded that the mere fact that the claimant did not receive the determination order was not sufficient to rebut the presumption of successful mailing. The Referee specifically noted the absence of any evidence of processing errors, incorrect address, lack of mailing, or any other circumstance which would rebut the presumption of successful mailing. The claimant requested Board review, and on review, the Board affirmed and adopted the Referee's order, including the aforementioned findings and conclusion. Anton V. Mortensen, 42 Van Natta 1183 (1990) (hereinafter called Mortensen II).

This case is distinguishable from Mortensen II. Here, the parties stipulated at hearing that claimant's copy of the January 11, 1990 Determination Order, which was mailed to claimant's last known address on January 11, 1990, was returned as undeliverable to the Evaluation Section because claimant had moved. The copy was then sent to the insurer on February 23, 1990 with a request to forward it to claimant's correct address. Despite having claimant's correct address, the insurer did not successfully mail the Determination Order to claimant until February 20, 1991, almost a year later.

Unlike Mortensen II, the record establishes that claimant's copy of the Determination Order was not mailed to claimant's correct address on the date of issuance. Moreover, claimant's copy was returned to the Evaluation Section as undeliverable. Finally, the insurer had possession of claimant's copy, but did not mail it to claimant until February 20, 1991 (more than one year after issuance of the Determination Order and nearly one year after the Evaluation Section had referred claimant's copy to the insurer).

Based on these findings, we adhere to our conclusion that the presumption of successful mailing was rebutted in this case, and that the statutory appeal period was tolled until the successful mailing to claimant on February 20, 1991. We conclude, therefore, that claimant's April 1, 1991 hearing request was timely.

Accordingly, our February 24, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 24, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RENE G. GONZALEZ, Claimant**
WCB Case No. 91-15032
ORDER ON RECONSIDERATION
James L. Edmunson, Claimant Attorney
Philip H. Garrow, Attorney
Kevin L. Mannix, P.C., Defense Attorneys

On January 21, 1993, we withdrew our December 22, 1992 order which had affirmed a Referee's order that set aside Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for a right shoulder condition. We took this action to consider Liberty's contention that we had erroneously analyzed this compensability dispute as a "joinder case." We also granted claimant an opportunity to respond. Having received claimant's response, we proceed with our reconsideration.

Reiterating that responsibility was not an issue at the hearing, Liberty reasserts that claimant's right shoulder impingement syndrome is not compensable because he failed to establish that his work activities for Liberty's insured were the major contributing cause of a worsening of his underlying condition. For the reasons set forth in our prior order, we continue to hold that the claim is compensable because claimant has proven that his work activities as a meatcutter before and after working for Liberty's insured were the major contributing cause of his condition. See Medford Corporation v. Smith, 110 Or App 486 (1992), on remand Donald H. Smith, 44 Van Natta 737 (1992).

In any event, even if our analysis was limited to claimant's 18 month exposure with Liberty's insured, we would continue to find the claim compensable. In reaching such a conclusion, we rely on the opinion of Dr. Wigle, claimant's treating physician. See Taylor v. SAIF, 75 Or App 583 (1985).

Based on an accurate medical/work history and an ongoing familiarity with claimant's shoulder, elbow, and arm complaints, Dr. Wigle "directly related" claimant's right shoulder problems to his repetitive meatcutting activities "throughout his lifetime which according to history . . . has been [Liberty's insured] for approximately 18 months." (Ex. 21). Dr. Wigle did not expressly use the term "major contributing cause" when discussing the relationship between claimant's shoulder condition and his work activities with Liberty's insured. Nevertheless, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required).

Considering Dr. Wigle's understanding of claimant's history and condition, we find his opinion supporting a direct relationship between claimant's work activities (particularly the 18 months for Liberty's insured) sufficient to satisfy the statutory requirements of ORS 656.802. Consequently, claimant's occupational disease claim for his right shoulder condition is compensable.

Claimant is entitled to an additional attorney fee for services on reconsideration. See ORS 656.382(2). After consideration of the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services on reconsideration is $500, to be paid by the insurer. This fee is in addition to the attorney fee granted by our prior order. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented herein, we republish our December 22, 1992 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
**FRANCES I. BOWMAN, Claimant**
WCB Case No. 91-11879
ORDER ON REVIEW
Hollis Ranson, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of those portions of Referee Peterson's order that: (1) upheld the SAIF Corporation's aggravation denial of her right shoulder condition; (2) declined to award a penalty for an allegedly untimely denial; (3) found that her claim had not been prematurely closed; (4) declined to award permanent total disability; (5) affirmed an Order on Reconsideration which awarded no additional unscheduled permanent disability for her right shoulder condition; and (6) found that there had been no "de facto" denial of a right rotator cuff condition. SAIF cross-requests review of those portions of the Referee's order that: (1) set aside its "de facto" denial of claimant's cervical condition; (2) awarded claimant an assessed attorney fee for prevailing over SAIF's partial denial of a cervical strain; and (3) declined to allow SAIF an offset for overpayment of temporary disability benefits. On review, the issues are aggravation, premature closure, compensability, extent of permanent disability, penalties and attorney fees, and offset. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of his last sentence in that section.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

The Referee concluded that claimant had not established a compensable aggravation because she had not proven objective findings to support a worsening of her right shoulder condition.

On review, claimant argues that her attending physician has provided treatment for increased pain she sustained following an independent medical examination (IME). SAIF contends that claimant has not established an aggravation because her alleged worsening took place before the last award of compensation.

We conclude that, regardless of whether claimant has objective findings of a worsened condition, she has not proven a worsening since the last award of compensation. Claimant's IME was performed on April 9, 1991. On April 11, 1991, claimant called Dr. Hendricks to inform him that following his exam, her pain had flared up and had not subsided. A Determination Order issued April 22, 1991, and subsequently claimant's treating doctor, Dr. Samsell, reported that claimant had not suffered an objective worsening of her condition.

Under the circumstances, we agree with SAIF that claimant has not proven a worsening since the last award of compensation, which was the April 22, 1991 Determination Order. See McDonald v. Roseburg Forest Products, 114 Or App 486 (1992). We therefore affirm the Referee on the issue of aggravation.

### Penalty/untimely aggravation denial

We adopt the Referee's conclusions and opinion on the penalty issue.

### Premature closure

Although we note that the dispositive date for determining whether a claim has been prematurely closed is the date upon which the Determination Order issues, we agree with the Referee's ultimate conclusion that claimant has not met her burden of proof. In other words, we find that claimant has not established that, at the time of the April 22, 1991 Determination Order, further material improvement would reasonably be expected from medical treatment or the passage of time. Accordingly, claimant has not shown that her claim was prematurely closed.

Compensability

SAIF contends that the Referee determined an issue that was not raised by the parties when he found that claimant had a compensable neck strain. SAIF argues that the only issue pertaining to claimant's neck condition was compensability of her current condition.

We conclude that the issue of compensability of claimant's cervical condition was properly before the Referee. In opening remarks, claimant's counsel asserted that the cervical strain was a result of claimant's 1985 injury, and he further contended that there had been a "de facto" denial of the cervical strain. (Tr. 6, 7).

Additionally, we agree with the Referee that the medical record supports the compensability of claimant's neck strain in 1985. See e.g., Ex. 161-9. We therefore affirm the Referee on the issue of compensability.

Permanent total disability

We adopt the Referee's conclusions and opinion on the issue of permanent total disability, with the following supplementation.

On review, claimant argues that the Referee should have taken her cervical and headache conditions into account in determining whether she was permanently and totally disabled. Claimant also contends that all of the vocational experts involved in the case have found that, especially when her headache condition is considered, she is unable to work.

We first conclude that there is no evidence that claimant is permanently and totally disabled on a physical basis alone. On January 3, 1991, Dr. Hendricks reported that claimant was capable of "some sort of gainful employment," although it would need to be modified work. On January 15, 1991, claimant's treating doctor, Dr. Samsell, concurred with Dr. Hendricks' opinion. Accordingly, we next determine whether claimant is permanently and totally disabled under the "odd-lot" doctrine. See Welch v. Banister Pipeline, 70 Or App 699 (1984).

In the present case, both vocational experts Gailey and McLean testified that claimant would be employable. Vocational expert McNaught, however, testified that based upon claimant's complaints of headache and shoulder pain, and her statements that approximately one day a week she is disabled for eight to fourteen hours at a time, claimant would be unemployable because she could not be a dependable worker.

At the outset, we do not find that claimant has established that her headache condition is related to her industrial injury. Additionally, we rely upon the physical capacities assessment of claimant's treating physician and the IME, rather than claimant's own assessment of her capabilities. See Theodore E. Lance, 42 Van Natta 1995 (1990). Moreover, because of inconsistencies in testing and references throughout the record to claimant's non-organic pain behavior (Ex. 161, 160, 152), we conclude that claimant's treating physician is in the best position to provide an opinion with regard to her physical capabilities and her ability to work. Lance, supra.

Finally, because Dr. Samsell has agreed that claimant is capable of performing modified work, we are not persuaded by the opinion of Mr. McNaught, who stated that claimant's headache condition would preclude her from any type of work. See e.g. Jeff D. Powell, 42 Van Natta 791 (1990) (Vocational expert's opinion not considered in assessing a claimant's physical capacity). We therefore affirm the Referee on the issue of permanent total disability.

Extent of unscheduled permanent disability

We adopt the Referee's conclusions and opinion on the issue of extent of disability. See Thomas C. Moore, 43 Van Natta 1002 (1991).

"De facto" denial of right rotator cuff

We adopt the Referee's conclusions and opinion on the issue of a "de facto" denial of a right rotator cuff condition.

Offset

The Referee concluded that SAIF had not proven that it was entitled to an offset. We disagree.

On May 13, 1991, claimant was notified that an audit indicated that she had been overpaid temporary disability from January 4, 1991 through April 17, 1991. The letter also provided the overpayment amount. (Ex. 147). At hearing, SAIF raised the offset issue and stated that it had an overpayment in the amount of $5,032.77. (Tr. 5). However, claimant did not testify that she had never received the payments, nor has she provided rebuttal evidence that shows that SAIF's requested offset has been miscalculated. See Eldon E. Hunt, 42 Van Natta 2751 (1990).

Accordingly, we conclude that SAIF has shown evidence consistent with its argument that temporary total disability was overpaid during the time period of January 4, 1991 through April 17, 1991. Therefore, SAIF is entitled to offset the overpayment against future awards of permanent disability.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of compensability of a cervical condition, payable by SAIF. 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 that portion of claimant's cross-respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated June 4, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that declined to allow the SAIF Corporation an offset is reversed. SAIF is authorized to offset overpaid temporary disability benefits in the amount of $5,032.77 against any of claimant's future awards of permanent disability on this claim. The remainder of the Referee's order is affirmed. For services on review concerning the issue of compensability of a cervical condition, claimant's counsel is awarded a reasonable attorney fee of $400, to be paid by SAIF.

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In the Matter of the Compensation of
**WAYNE A. BURDICK, JR., Claimant**
WCB Case No. 92-01047
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of that portion of Referee Daughtry's order that found that his total unscheduled permanent partial disability award to date was 6 percent (19.2 degrees) unscheduled permanent disability. 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

We agree with the Referee's ultimate conclusion that claimant is entitled to a total award of 6 percent unscheduled permanent disability. However, we base our conclusion on the following reasoning.

Claimant's claim was closed by a July 16, 1991 Determination Order that awarded 22 percent unscheduled permanent disability; found claimant to be medically stationary as of November 15, 1990; and awarded temporary disability. The order provided that the insurer was ordered to pay claimant $7,040. Finally, the evaluator's worksheet showed that claimant's award was based on impairment findings for surgery, lost range of motion and loss of strength.

The Department subsequently issued a second Determination Order on July 30, 1991, which provided that the original determination was incorrect. The corrected order provided that the "total unscheduled award to date is $1,920." The Department's order further provided that "[t]his order becomes a part of and should be attached to the prior Determination Order, which remains the same in all other respects." The evaluator's worksheet indicated that claimant's award was 6 percent (19.2 degrees). The worksheet also showed that claimant's impairment was now based upon only surgery and lost range of motion.

The Referee found that the plain meaning of the second order was that it had combined with the first order and claimant was owed an additional $1,920, with all aspects of the first order remaining unchanged. The Referee also concluded that, although it was apparent that the intent of the Department was to reduce claimant's award, a literal reading of the second order showed that only the dollar amount had been changed, and there was no change in the degrees or percentage of permanent disability.

We do not agree with the Referee that the second order indicated that claimant was to be paid an additional amount by the insurer while the remaining information remained the same. While we agree that the second order is somewhat unclear and incomplete, it does provide that it was issued for the purpose of correcting the prior order. See generally Virgil D. Keller, 44 Van Natta 795 (1992). Furthermore, although the Referee noted that claimant may not have received the evaluator's worksheet (and even if he had received it, understandably might not have been able to decipher it), the evaluator's worksheet was copied to claimant's attorney and shows that the basis for the original calculation had been changed. The worksheet also provides that claimant's award was 6 percent, or 19.2 degrees unscheduled permanent disability.

Under the circumstances, we conclude that the second order corrected the first order for a net result of 6 percent unscheduled permanent disability. Pursuant to the corrected order, therefore, claimant's total award to date was 6 percent.

Finally, we conclude that, although the Order on Reconsideration was issued without the appointment of a medical arbiter, the order was valid for review as claimant did not disagree with the impairment findings used in the order. See Doris C. Carter, 44 Van Natta 769 (1992). We note that, although claimant subsequently disagreed with the impairment findings used in the second determination order and requested reconsideration on that order, the Department found that an Order on Reconsideration had already been issued. We conclude that the Department's actions in that respect are consistent with our above conclusion that there is essentially only one, corrected Determination Order. Moreover, we note that, at the time claimant requested reconsideration of the first order, he was aware that the second order had issued but did not request reconsideration on the basis that he disagreed with the impairment findings.

Consequently, we conclude that the Referee properly addressed the merits of claimant's extent claim. We adopt the Referee's "Opinion and Conclusion" on that issue, and agree with his finding that claimant's total award to date is 6 percent unscheduled permanent disability.

## ORDER

The Referee's order dated May 14, 1992 is affirmed. The January 15, 1992 Order on Reconsideration is also affirmed.

In the Matter of the Compensation of
**DANIEL DOMINGUEZ, Claimant**
WCB Case No. 92-02952
ORDER ON REVIEW
Vance D. Day, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Nichols' order which found that claimant had timely requested a hearing from its denial of claimant's left shoulder injury claim. On review, the issue is timeliness of claimant's hearing request.

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

SAIF objects to the Board's holding in Thomas E. Edison, 44 Van Natta 211 (1992), which determined that a claimant must receive actual or constructive notice of a claim denial before the time limit for requesting a hearing under ORS 656.319(1)(a) begins to run. See ORS 656.262(8). In Edison, the denial was mailed to claimant's correct address, but was not received by claimant or anyone else at the address. SAIF seeks to distinguish Edison, arguing the current denial was mailed to claimant's last known address from which claimant had moved without leaving a forwarding address.

The Court of Appeals has agreed with the Board's interpretation of the statutory change as explained in Edison. The court reasoned that "the legislature deleted the mailing language from ORS 656.262(8) in order to make notification contingent on actual or constructive receipt of the denial." SAIF v. Edison, 117 Or App 455, 458 (1992).

In light of the Edison reasoning, we agree with the Referee's conclusion that claimant did not receive actual or constructive notice of SAIF's denial until February 1992, when he was informed of the denial by his attorney. Inasmuch as claimant requested a hearing within 60 days of this notice, we affirm the Referee's holding that the denial was timely appealed.

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 is $750, to be paid by the SAIF Corporation. 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 July 24, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
**IVAN A. LEHMAN, Claimant**
WCB Case No. 91-15319
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of that portion of Referee Crumme's order that affirmed an Order on Reconsideration awarding him 16 percent (51.2 degrees) unscheduled permanent disability benefits and no scheduled permanent disability benefits for a low back injury. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

On review, claimant argues that because the closing examination was performed in December 1990, the standards in effect at that time (WCD Admin. Order 6-1988, as modified by WCD Admin. Order 15-1990) should be used to rate extent of permanent disability. We disagree. For claims in which the worker was medically stationary after July 1, 1990, the disability rating standards in effect on the date of the Notice of Closure or Determination Order control. Former OAR 436-35-003(3). Here, claimant's claim was closed by Determination Order dated May 3, 1991. Thus, the Referee properly applied the standards in effect April 1, 1991. Former OAR 436-35-020 through 436-35-260 apply to the rating of claimant's scheduled permanent disability; former OAR 436-35-270 through 436-35-450 apply to the rating of claimant's unscheduled permanent disability. (WCD Admin. Order 2-1991).

Claimant next contends that he returned to modified, rather than regular work, and thus should be allowed an award for a loss of earning capacity greater than that attributable to the impairment alone. However, Dr. Jura, claimant's attending physician, released claimant to return to his at-injury job without restrictions. For workers who at the time of the Determination Order have a physician's release to regular work, the values for the age, education, and adaptability factors is 0. Former OAR 436-35-290(2); OAR 436-35-300(2); OAR 436-35-310(2). The Referee correctly applied the rules and awarded claimant 16 percent disability based on impairment resulting from reduced range of motion and surgeries. He properly did not consider claimant's age, education, or adaptability factors.

ORDER

The Referee's order dated July 1, 1992 is affirmed.

In the Matter of the Compensation of
**TRACI L. LUKESH, Claimant**
WCB Case No. 92-01723
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Crumme's order that: (1) awarded claimant 5 percent (16 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration awarded claimant no permanent disability; and (2) declined to authorize an offset for the insurer's alleged overpayment of temporary disability benefits against the award of permanent disability. On review, the issues are extent of unscheduled permanent disability and offset. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of "facts" number 2 and 6. In addition, we supplement with the following.

Claimant underwent an examination by the Orthopaedic Consultants on February 2, 1991. The Consultants noted no muscle weakness or impaired sensation in any of the lumbosacral dermatomes. They did, however, note inconsistent and nonanatomical responses. They, therefore, concluded that they could not verify permanent impairment.

On April 2, 1991, Dr. Jensen found her assessment of claimant's impairment "compatible with the findings by [the Orthopaedic Consultants]." Dr. Jensen could likewise "not establish a rating of impairment."

A May 20, 1991 Determination Order awarded claimant no permanent disability. Claimant requested reconsideration of that order, indicating disagreement with the impairment findings of the attending physician.

Claimant was, therefore, examined by medical arbiter Dr. Ayers on January 18, 1992. Dr. Ayers reported that claimant's flexion on range of motion testing was inconsistent, and varied depending on whether claimant was sitting, standing, or lying down. He noted that claimant reported diffuse tenderness, but demonstrated good muscle strength. As did the previous physicians, Dr. Ayers concluded that there were "[n]o objective findings to bear out [claimant's] subjective complaints," and opined that there was no "significant evidence of permanent or partial impairment."

The January 30, 1992 Order on Reconsideration affirmed the Determination Order in all respects. Claimant then sought review of the reconsideration order. The only issue at hearing was extent of permanent disability. After the Referee's Opinion and Order, the insurer moved for abatement and reconsideration of the permanent disability award made therein. The insurer also asked that the Referee authorize an offset of temporary disability benefits allegedly paid after claimant's medically stationary date against the award of permanent disability. The insurer presented no evidence of the alleged overpayment. Claimant did not object to the insurer raising the offset issue after the close of hearing.

## CONCLUSIONS OF LAW AND OPINION

### Unscheduled Permanent Disability

The Referee awarded claimant 5 percent impairment for a chronic low back condition. We disagree.

Claimant became medically stationary on April 2, 1991, and her claim was closed by Determination Order on May 20, 1991. The rules in effect on the date of the Notice of Closure or Determination Order control. Thus, the rules in effect April 1, 1991 apply. (See WCD Admin. Order 2-1991).

The Referee found claimant entitled to a value for a chronic condition based on Drs. Jensen and Ayers' findings that claimant reported tenderness to palpation in her low back. Claimant argues on review that these reports of tenderness constitute "objective findings of impairment" sufficient to support the Referee's 5 percent award. See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 44 Van Natta 1505 (1991).

Pain is considered in the applicable standards to the extent that it results in measurable impairment. Former OAR 436-35-320(2). If there is no measurable impairment as measured by a physician there is no award of unscheduled permanent disability. Former OAR 436-35-270(2); 436-35-320(1); William K. Nesvold, 43 Van Natta 2767 (1991).

Under former OAR 436-35-320(5), "[a] worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition." Here, although the doctors reported that claimant has tenderness in her low back, they found no measurable impairment attributable to her back injury.

On February 2, 1991, prior to claim closure, claimant was examined by the Orthopaedic Consultants. Because their examination revealed inconsistent, nonanatomical, and invalid findings, the Consultants opined that claimant had no impairment. Dr. Jensen, claimant's attending physician, concurred with the Consultants' findings, and noted that they comport with her own assessment of claimant. Thus, although both the Consultants and Dr. Jensen reported claimant's subjective complaints of pain, they did not verify them.

Further, on January 18, 1992, medical arbiter Dr. Ayers examined claimant. He noted tenderness of claimant's hips and low back to palpation, and inconsistent range of motion findings. Based on this examination, the arbiter concluded that there were no objective findings to support claimant's subjective complaints. Accordingly, as did the other physicians, Dr. Ayers opined, claimant has no permanent impairment.

Because all examining physicians in this record have indicated an inability to verify measurable impairment in this claimant, we conclude that she has failed to prove entitlement to the 5 percent permanent disability award made by the Referee. Consequently, we conclude that claimant has failed to establish that she has a chronic condition limiting repetitive use of her low back. The award made by the Referee will be reversed.

Offset

On review, claimant objects to the insurer raising the offset issue for the first time in its motion for reconsideration of the Referee's order. We conclude, however, that whether or not the insurer's issue was properly raised, the insurer is not entitled to the offset it seeks. As did the Referee, we conclude that the insurer failed to produce evidence that it is entitled to an offset. Eldon E. Hunt, 42 Van Natta 2751, 2753 (1990); Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988).

Attorney Fees

Although claimant has successfully defended against the insurer's demand for an offset, no attorney fee is awardable; an offset, even if successfully asserted, would not have "reduced" claimant's compensation. See ORS 656.382(2); Paul E. Klutz, 44 Van Natta 533 (1992).

ORDER

The Referee's order dated May 21, 1992, as reconsidered July 20, 1992, is reversed in part and affirmed in part. That portion of the order that awarded claimant 5 percent (16 degrees) unscheduled permanent disability is reversed. The Order on Reconsideration is reinstated and affirmed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**JOHN E. McALPINE, Claimant**
WCB Case No. 91-11945
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Miller, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that affirmed a Director's order which found that claimant was not entitled to vocational assistance. Claimant also requests penalties and attorney fees for the insurer's alleged unreasonable failure to pay vocational assistance. On review, the issues are vocational assistance, penalties, and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to vocational assistance on the sole basis that his claim was reopened under the Board's own motion jurisdiction. Although we agree that claimant is not entitled to vocational assistance, we base our decision on the following analysis.

On August 16, 1991, a Director's order dismissed claimant's request for an administrative review of claimant's eligibility for vocational assistance. Reasoning that the Board's own motion reopening cannot be used as the basis for potential eligibility for vocational assistance, the Director concluded that the Workers' Compensation Division lacked jurisdiction to decide claimant's likely eligibility for vocational benefits.

We review a decision of the Director concerning vocational assistance pursuant to ORS 656.283(2). The Director's order may be modified only if it: (1) violates a statute or a rule; (2) exceeds the statutory authority of the agency; (3) was made upon unlawful procedure; or (4) constituted an abuse of discretion. ORS 656.283(2).

Subsequent to the Referee's decision, we decided David F. Meissner, 45 Van Natta 249 (1993), on recon 45 Van Natta 384 (1993). In Meissner, the Director issued an order which used the same language and reasoning as is found in the present order to dismiss the claimant's request for review of eligibility for vocational assistance. There, we concluded that the Director had jurisdiction to decide a worker's eligibility for vocational services, even if the worker is ultimately found ineligible for such services.

Turning to the issue of the Meissner claimant's eligibility for vocational assistance, we held that the Director had violated his statutory authority by denying assistance to the claimant solely on the ground that his aggravation rights had expired. The claimant had otherwise satisfied all of the statutory eligibility requirements of ORS 656.340(6). Specifically, we found that the claimant was available for assistance in Oregon, had sustained a worsening of his compensable condition which his physician believed would prevent his return to regular work, and had received no previous vocational assistance.

Here, as in Meissner, the Director had jurisdiction to determine the vocational assistance dispute. Likewise, the expiration of claimant's aggravation rights is not a valid reason to declare claimant ineligible for vocational assistance. Nevertheless, the record does not establish that claimant is otherwise eligible for vocational assistance.

ORS 656.340(6)(a) provides that "[a] worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of the injury, and the worker has a substantial handicap to employment." A "substantial handicap to employment" occurs when "the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in a suitable employment." ORS 656.340(6)(b)(A). In addition to employment for which the claimant has the necessary physical capacities, knowledge, skills, and abilities, "suitable employment" means employment producing wages

within 20 percent of the wages paid for the claimant's regular work, and employment that is within the same area that the claimant customarily worked or within reasonable commuting distance from the claimant's residence. ORS 656.340(6)(B).

Here, unlike Meissner, supra, no physician opined that claimant is unable to return to his regular work. Specifically, in April 1991, Dr. Franks, claimant's treating neurologist, estimated that claimant would be medically stationary in about two months. (Ex. 29). Although not expressly addressing claimant's ability to return to regular work, Dr. Franks had previously reported, without contradiction, claimant's intention to return to regular work. (Ex. 22).

On this record, claimant has not established that he has a "substantial handicap to employment." ORS 656.340(6). Thus, he is not eligible for vocational services. Accordingly, we modify the Director's order to provide that claimant is not entitled to vocational services on the basis that he has not established a "substantial handicap to employment."

We note that, if claimant's circumstances change, he may request a redetermination of his eligibility for vocational assistance. OAR 436-120-035, 436-120-040; 436-120-055; John R. Coyle, 45 Van Natta 325 (1993).

Penalties and Attorney Fees

At hearing and on review, claimant argues that he is entitled to penalties and assessed attorney fees pursuant to either ORS 656.262(10) or 656.382(1) for the insurer's allegedly unreasonable resistance to payment of vocational assistance benefits. Because claimant is not entitled to vocational assistance benefits, the insurer's failure to pay those benefits was not unreasonable. In any event, the Board and Hearings Division are without jurisdiction to assess penalties in vocational matters. ORS 656.745; OAR 436-120-270; Abraham Heamish, 42 Van Natta 785 (1990); Joel I. Harris, 36 Van Natta 829 (1984), aff'd mem 72 Or App 591 (1985).

ORDER

The Referee's order dated February 21, 1992 is affirmed.

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March 19, 1993 Cite as 45 Van Natta 509 (1993)

In the Matter of the Compensation of
**JULIE L. MILLER, Claimant**
WCB Case No. 92-02480
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of Referee Thye's order that: (1) declined to reinstate a Determination Order which had been set aside by an Order on Reconsideration; (2) awarded claimant an assessed attorney fee; and (3) awarded claimant a penalty for the employer's allegedly unreasonable conduct in requesting a hearing. On review, the issues are claim processing, and penalties 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 OPINION

Order on Reconsideration

We adopt the Referee's "Conclusions and Opinion" on this issue.

Attorney Fee

The Referee concluded that claimant was entitled to an assessed attorney fee pursuant to ORS 656.382(2), as the employer had requested a hearing and claimant's compensation was not disallowed or reduced. We reverse.

The Referee did not, as claimant contends, affirm the Order on Reconsideration. Rather, the Referee reasoned that the employer's subsequent issuance of a Notice of Closure had resolved the employer's "medically stationary" issue. Under the circumstances, we conclude that there was no finding that claimant's compensation should not be disallowed or reduced. We, therefore, reverse the Referee's attorney fee award.

Penalty

We adopt the Referee's "Conclusions and Opinion" on the penalty issue.

We conclude that no attorney fee is available for claimant's counsel's services on review concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986). Moreover, consistent with our holding above that the Referee's order did not award compensation, we conclude that no attorney fee is available pursuant to ORS 656.382(2) for claimant's counsel's services on review.

ORDER

The Referee's order dated July 10, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that awarded an assessed attorney fee of $1,000 is reversed. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**CRAIG F. NAKUNZ, Claimant**
WCB Case No. 91-16931
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Hooton.

The insurer requests review of Referee Mills' order that increased claimant's unscheduled permanent partial disability award for an asthma condition from 23 percent (73.6 degrees), as awarded by an Order on Reconsideration, to 40 percent (128 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

In February 1990, claimant filed a claim for asthma due to his exposure to western red cedar during his employment as a greenchain worker. His claim was accepted as disabling in April 1990.

Claimant's claim was closed by a May 22, 1991 Determination Order that found claimant to be medically stationary on February 26, 1991 and awarded 20 percent unscheduled permanent disability. Claimant's award was based on a February 26, 1991 closing examination and report by Dr. Feldstein, claimant's attending physician. On September 13, 1991, claimant's counsel sent Dr. Feldstein an extensive fifteen page questionnaire concerning the extent of claimant's permanent disability. (Ex. 13). The questionnaire described the various classes of respiratory impairment provided by the standards and asked Dr. Feldstein to respond to the enumerated questions by using the standards as described. Dr. Feldstein completed the questionnaire on October 18, 1991. Dr. Feldstein noted that her responses were based on an October 17, 1991 examination (Ex. 13-5).

On November 4, 1991, claimant requested reconsideration of the Determination Order. With his request, claimant submitted Dr. Feldstein's October 18, 1991 report. On November 22, 1991, an Order on Reconsideration issued which increased claimant's award of unscheduled permanent disability to 23 percent. The Order on Reconsideration noted that the Appellate Unit of the Workers' Compensation Division did not consider Dr. Feldstein's October 18, 1991 report because it was based on a post-closure

examination. The order further noted that the Appellate Unit had relied on Dr. Feldstein's February 26, 1991 closing examination and report.

Claimant is 42 years of age and has a twelfth grade education. The position which claimant successfully performed in the preceding ten years which has the highest specific vocational pursuit (SVP) level was as a glue line worker (DOT # 569.685-042). Claimant has received training as a truck driver and is working in that occupation. Claimant's job at-injury was in a heavy capacity. As a result of the compensable exposure, claimant is now performing work in a medium capacity. Claimant has a long term sensitivity to Western Red Cedar. Claimant is permanently restricted from exposure to strong fumes or dust. Claimant has a Class 2 respiratory impairment as a result of his compensable asthma condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee considered Exhibit 13, which is Dr. Feldstein's October 18, 1991 report. Based on that report, the Referee increased claimant's award of unscheduled permanent disability to 40 percent. The insurer contends that the Referee erred in considering Exhibit 13 because it is based on a post-closure examination. We do not need to reach that question. We conclude that, regardless of whether the Referee erred by receiving Exhibit 13 into evidence, claimant has established entitlement to the 40 percent unscheduled permanent disability award granted by the Referee based on Dr. Feldstein's February 26, 1991 closing report.

Relying solely on Dr. Feldstein's closing report, the Appellate Unit rated claimant's impairment as Class 2, i.e., the same class rating as provided in Exhibit 13. (See Ex. 15-4). At hearing, the Referee also found claimant to be entitled to a Class 2 rating. The Referee additionally awarded claimant an impairment value because he "is prevented from engaging in some work-related activities due to reactions that he will have when exposed to certain agents." Dr. Feldstein expressly noted this restriction in his closing report, stating that claimant "will need to be permanently restricted from strong fumes or dust."

The parties have stipulated that the value for claimant's age and education factors is 5. Claimant's former work was heavy. Claimant is no longer able to perform heavy work, but has returned to work in the medium capacity. Therefore, claimant's residual functional capacity is in the medium range. OAR 436-35-270(3)(d). Accordingly, pursuant to OAR 436-35-310(3), claimant is entitled to an adaptability value of 3.

The Appellate Unit assigned a value of 5 percent for a Class 2 respiratory impairment. The Referee assigned a value of 18 percent for a Class 2 impairment. OAR 436-35-385(2) provides that a Class 2 respiratory impairment receives an impairment value of 18 percent. [Former OAR 436-35-385(2)(WCD Admin. Order 6-1988) provided a range of values for a Class 2 impairment of 10-25 percent. That version of the rule is not applicable here]. Therefore, the Referee correctly awarded claimant 18 percent for his Class 2 respiratory impairment due to his compensable asthma condition. See OAR 436-35-385(2) & (4).

In addition, Dr. Feldstein indicated that claimant has a long term sensitivity to Western Red Cedar and permanently restricted claimant from strong fumes and dust. OAR 436-35-450(1)(b) allows for an award of 8 percent where exposure to physical, chemical or biological agents causes a reaction which prevents some regular work-related activities. Therefore, we agree with the Referee that claimant is entitled to an additional impairment value of 8 percent under that provision. Claimant's impairment values (18) and (8) are combined for a total impairment value of 25. OAR 436-35-320(3).

When claimant's value for age and education (5) is multiplied by his adaptability value (3), the result is 15. OAR 436-35-280(6). This value is added to claimant's impairment value (25) for a total of 40. OAR 436-35-280(7). Thus, the extent of claimant's unscheduled permanent disability under the standards is 40 percent. Accordingly, the Referee correctly evaluated the extent of claimant's unscheduled permanent disability.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 permanent disability issue is $1,000, 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 20, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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In the Matter of the Compensation of
**ARTHUR D. SIMON, Claimant**
WCB Case No. 91-12398
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The SAIF Corporation requests review of that portion of Referee Schultz's order that awarded 5 percent (16 degrees) unscheduled permanent disability for a chronic hernia condition, whereas a Determination Order, as affirmed by an Order on Reconsideration, had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

SAIF contends that the Referee erred in awarding 5 percent impairment for a chronic condition limiting repetitive use. We agree.

The Referee found the Director's temporary rules effective October 1, 1990 and November 20, 1990 (WCD Admin. Orders 15-1990 and 20-1990) invalid and, therefore, applied the permanent rules adopted in WCD Administrative Order 6-1988, effective January 1, 1989. Subsequent to the Referee's order, we held that the Board and its Hearings Division have no authority to declare invalid a rule promulgated by the Director. Eileen N. Ferguson, 44 Van Natta 1811 (1992). Furthermore, we held that we must apply the applicable standards adopted by the Director. Id. Accordingly, we rate the extent of claimant's unscheduled permanent disability under the disability standards in effect on the date of the February 20, 1991 Determination Order, including the temporary rules in effect on that date.

At hearing, claimant sought only a 5 percent award for a chronic condition. Former OAR 436-35-320(1) provides that a worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. All physician impairment ratings shall be established on the basis of objective medical evidence supported by objective findings from the attending physician or as provided in 436-35-007(8) and (9). Former OAR 436-35-320(1). Impairment findings made by a physician other than the worker's attending physician at the time of claim closure shall be used to determine impairment if the worker's attending physician concurs with the findings. Former OAR 436-35-007(8).

Dr. Mollerus, claimant's treating physician and surgeon, examined him on November 1, 1990. He made no impairment findings at that time and released claimant to regular work involving extremely heavy lifting and straining. (Ex. 12). On November 20, 1990, claimant was independently examined by Dr. Mayer who found claimant had some minimal permanent impairment equal to 5 percent based on

multiple surgeries and insertion of graft material. (Ex. 13). Dr. Mollerus did not concur in the findings. See former OAR 436-35-007(8). Dr. Mayer's opinion raises some doubt about the reliability of Dr. Mollerus' opinion. However, ORS 656.245(3)(b)(B) restricts the source of impairment findings to attending physicians and medical arbiters. See ORS 656.268(7). The medical arbiter found that claimant had permanent impairment up to 5 percent based on removal of the inguinal nerve and referring to the AMA Guides to the Evaluation of Permanent Impairment, Third Edition (1988). However, the standards do not allow a permanent disability award based on that finding. The Department failed to account for this impairment finding by staying the matter and adopting a temporary rule pursuant to ORS 656.726(3)(f)(C). Moreover, even if we were to find that such impairment should be compensated, we lack authority to remand the case to the Director for such rulemaking. Gary D. Gallino, 44 Van Natta 2506 (1992). (Ex. 26).

Accordingly, based on the current standards, claimant has failed to establish a chronic condition or any other permanent impairment on the basis of medical evidence supported by objective findings.

ORDER

The Referee's order dated December 20, 1991 is reversed in part and modified in part. That portion of the order that awarded claimant 5 percent (16 degrees) unscheduled permanent disability is reversed. The Determination Order/Order on Reconsideration is affirmed. That portion of the order allowing the SAIF Corporation to recover its overpayment of $509.26 against the Referee's permanent disability award is modified to allow the offset against future awards of benefits for permanent partial disability.

**Board Member Hooton dissenting.**

I disagree with the outcome in this case. The treating physician made no findings regarding impairment. However, of the three doctors whose opinions comprise this record, two, including the medical arbiter, did make findings of impairment. Both of those doctors concluded that claimant had impairment, and both agreed as to the degree of that impairment, even though the bases for their findings were different. Substantial justice, still the guiding principle of ORS 656.283, requires that claimant receive an award for his proven loss of earning capacity. However, by relying on three cases whose only function is to increase the technical requirements imposed by a system that no longer reflects its purpose, (a "fair and just" administrative system for the prompt delivery of benefits to injured workers, (ORS 656.012)), the majority deprives this claimant of his meager award.

The majority applies Eileen N. Ferguson, 44 Van Natta 1811 (1992), for the proposition that the Board is without authority to invalidate the temporary rules for the rating of impairment adopted by the Department in October 1990, and that the Board must, therefore, apply the rules adopted by the Director. I disagree, for the reasons set out in my extensive dissent in that same order. I refer to the parties to that dissent for an understanding of the reasoning on which I rely.

In addition, I would note that, in Ferguson, the Board did not examine the requirements of its own rule at OAR 438-10-010. That rule requires the Board to apply the rules for the rating of impairment "in effect" on the date of closure. As I explained in my dissent in Ronald Cameron, 45 Van Natta 219 (1993), that rule requires the Board to establish which rules were "in effect" on the date of closure, thus requiring the very analysis which the Board concluded we were without authority to perform in Ferguson. To explain the contradiction the majority concluded that any rule "in existence" on the date of closure, was a rule "in effect" for purposes of OAR 438-10-010. The absurdity of that conclusion is amply discussed in my dissent in Cameron.

Finally, the majority relies upon Gary D. Gallino, 44 Van Natta 2506 (1992) for the proposition that only the Director may make findings that the rules do not adequately provide for a claimant's actual impairment, so as to implement the procedures for the adoption of a temporary rule. They further conclude that this Board lacks authority to remand for the adoption of a rule when the evidence indicates that impairment exists which is not covered by the current rules for the rating of impairment.

I explained my disagreement with the majority's position regarding the Board's remand authority in Olga I. Soto, on recon, 44 Van Natta 1609, 1610 (1992). I am unable to conclude that the

legislature intended to create an administrative system whose purpose was to impose technical hurdles to deprive claimants of that compensation to which they are entitled. I am convinced that the legislature adopted the current system for rating and awarding impairment to reduce the number of erroneous determinations through additional administrative processes within the Department, and to increase confidence in the accuracy of those awards so that litigation would be reduced. By adopting a line of reasoning that creates hurdles where none were intended, the Board has painted itself into a corner in which it regrets the injustices that inevitably result, but, nevertheless, lacks the ability to accomplish the "substantial justice" required by the statute.

I acknowledge that the changes to the workers' compensation system wrought by the Special Session of 1990 were often insufficiently considered, insofar as the interplay of various statutes could produce an outcome that violates the purpose of the law. Nevertheless, the legislature relied upon the Department and the Board, to sanely interpret those changes within the purpose of the law, and to effectuate the legislative intent while preserving the purpose and application of the law. In that effort we have failed. Therefore, I must, regretfully, dissent.

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March 19, 1993 Cite as 45 Van Natta 514 (1993)

In the Matter of the Compensation of
**KATHLEEN A. WILFONG, Claimant**
WCB Case Nos. 92-02770 & 91-14341
ORDER OF ABATEMENT
Schneider & DeNorch, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation requests reconsideration and abatement of our March 4, 1993 Order on Review that affirmed a Referee's order which: (1) set aside SAIF's denial of claimant's aggravation claim for her neck condition; and (2) upheld Sedgwick James' denial of claimant's "new occupational disease" claim for the same condition. SAIF contends that our order did not address its contention that claimant's current condition was not materially related to her accepted claim.

In order to consider SAIF's motion, we withdraw our March 4, 1993 order. Claimant and Sedgwick James are granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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March 19, 1993 Cite as 45 Van Natta 514 (1993)

In the Matter of the Compensation of
**NORMA D. YUNDT, Claimant**
WCB Case No. 92-02143
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Neidig and Gunn.

Claimant requests review of Referee Spangler's order which: (1) upheld the SAIF Corporation's partial denial of her current low back condition; and (2) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable partial denial. On review, the issues are compensability, penalties and attorney fees.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated June 4, 1992 is affirmed.

**Board Member Gunn dissenting.**

The Referee and majority found that claimant had not proven the compensability of her current condition, diagnosed as L5-S1 degenerative disc disease. Whether claimant's current condition is compensable under ORS 656.005(7)(a)(B) involves both legal and factual questions. The correct legal inquiry is whether the compensable injury is the major contributing cause of her disability or need for treatment. I believe claimant has sustained this burden.

The evidence establishes that claimant's preexisting mild degenerative joint disease at L5-S1 was asymptomatic prior to the compensable injury. There is no evidence, medical or otherwise, to the contrary. Thus far, the majority, the Referee and I agree.

My opinion, however, must part ways with the majority and the Referee, based upon the legal and factual analysis of the medical evidence in the record. Specifically, Dr. Woolpert found that claimant's current condition was attributable to mild degenerative disc disease. He was also of the opinion that the compensable event rendered claimant's preexisting condition symptomatic. Under these circumstances, claimant's current condition should be found compensable, inasmuch as the compensable injury was and remains the major contributing cause of her current disability and need for medical treatment. See Hana G. Ali, 44 Van Natta 1086 (1992); LaDonna F. Burk, 44 Van Natta 781 (1992).

I note that although the majority and Referee applied ORS 656.005(7)(a)(B), neither applied that statutory provision in the context of an asymptomatic preexisting condition made symptomatic after the compensable injury. Therefore, I suggest that the Referee and majority came up short in applying the proper legal standard. Accordingly, I turn now to the evidence to determine if it would support the majority's findings under a legal standard which analyzes the preexisting condition in light of its prior asymptomatic nature and subsequent symptomatic condition after the compensable injury.

A May 15, 1991 x-ray revealed that claimant exhibited an "essentially normal lumbar spine for age." (Ex. 4). A July 11, 1991 MRI revealed: "Mild facet degenerative change bilaterally at the L5-S1 and L4-5 levels, but without significant hypertropic change." (Ex. 11).

After examining claimant and reviewing the diagnostic data, Dr. Woolpert opined that claimant "had a temporary symptomatic exacerbation of this [the preexisting degenerative facet condition] due to her work injury, which did contribute to her temporary need for care, but I feel that any impact that was caused by the work injury of 6/20/90 now has subsided and the patient's current need for treatment would be that of the underlying facet degenerative sclerosis." (Ex. 14).

In sum, Dr. Woolpert has reported that claimant has experienced three separate conditions: (1) the initial muscular strain; (2) a temporary exacerbation of her degenerative disc disease due to the compensable injury; and (3) a current degenerative disc disease not caused by the compensable injury.

The first two are compensable. The third is not.

The glaring flaw here, however, is that Dr. Woolpert does not explain how he has been able to separately diagnose each condition with their respective separate causations. Dr. Woolpert has not explained how he determined the separate time periods and then designated when the strain ended, when the temporary exacerbation began and ended, and when the current condition effects alone began. Moreover, inasmuch as Dr. Woolpert has agreed that the compensable injury rendered the asymptomatic preexisting condition symptomatic, it is essential that he explain why claimant's current symptomatic condition is now unrelated to the compensable injury. Without such an explanation, that portion of Dr. Woolpert's opinion is lacking in logical and persuasive force. If the unexplained portion of Dr. Woolpert's opinion is excised from the rest of his opinion, we are left with an opinion which concludes that claimant's compensable injury rendered claimant's asymptomatic preexisting condition symptomatic, and therefore, her current resultant disability and medical treatment is compensable. I add, however, this would not be a determination that claimant's degenerative disc disease is itself compensable. Rather, it would represent a conclusion that claimant's current disability and need for treatment is attributable to her symptoms from the preexisting degenerative disc disease, the major contributing cause of which would remain, at this time, the compensable injury. See Hana G. Ali, supra at 1087. Such a conclusion is also consistent with the rest of the medical evidence.

The majority and Referee discounted Dr. Gordon's opinion on the basis that he had not reviewed the actual MRI films. However, the Referee and majority have disregarded the fact that Dr. Gordon reviewed the MRI results as depicted in Dr. Woolpert's opinion and in the MRI report. Therefore, Dr. Gordon's non-review of the actual MRI films would only become significantly relevant if the MRI report and Dr. Woolpert's recitation of the MRI films were inaccurate. Inasmuch as neither the Referee, the majority, nor I find that Dr. Woolpert's review of the MRI films are inconsistent with the MRI report, then Dr. Gordon's opinion should stand as persuasive. Furthermore, Dr. Gordon's opinion supports that portion of Dr. Woolpert's opinion that is not flawed. On that basis, I would find that claimant has established a compensable injury by the persuasive evidence as a whole.

Additionally, I make an ancillary note that legislative history supports a finding consistent with the legal standard I have discussed above. In thrashing out the effect of Senate Bill 1197 in the context of asymptomatic preexisting conditions, Representative Mannix testified that if, for example, a degenerative back problem became "symptomatic as a result of an occupational disease as part of a complex injury and [then it] should be compensable." Special Committee on Workers' Compensation, Senate Bill 1197, Tape 7, Side B at 382 (May 3, 1990).

Accordingly, because there is considerable evidence to support claimant's claim of compensability under the applicable law as discussed, I dissent on the issue.

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March 16, 1993 Cite as 45 Van Natta 516 (1993)

In the Matter of the Compensation of
**KENNETH S. TAYLOR, Claimant**
WCB Case Nos. 91-14266 & 91-14727
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of those portions of Referee Howell's order that: (1) set aside an Order on Reconsideration as invalid; and (2) found that jurisdiction over the matter remained with the Director. Claimant cross-requests review of that portion of the Referee's order which declined to award an assessed attorney fee for services at hearing. On review, the issues are jurisdiction and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Jurisdiction

We adopt the Referee's "Conclusions" on the issue of jurisdiction.

### Attorney fee

On review, claimant contends that he is entitled to an attorney fee pursuant to ORS 656.382(2) for his counsel's services at hearing, as claimant's compensation was not "disallowed or reduced." We disagree. Because the Referee found that he had no jurisdiction over this matter, he did not address the merits of the case. Accordingly, we do not agree that the Referee "found that claimant's compensation should not be disallowed or reduced." Consequently, we conclude that an attorney fee pursuant to ORS 656.382(2) was not warranted.

## ORDER

The Referee's order dated July 2, 1992 is affirmed.

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In the Matter of the Compensation of
**DELORES A. WILLIAMS, Claimant**
WCB Case No. 92-01878
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Barber's order that affirmed an Order on Reconsideration awarding her 23 percent (73.6 degrees) unscheduled permanent disability benefits for a left shoulder injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

We adopt the Referee's reasoning and conclusions regarding the extent of unscheduled permanent disability, but offer the following comment concerning the value assigned for the adaptability factor.

Claimant became medically stationary on August 20, 1991, and her claim was closed by Notice of Closure on September 16, 1991. The rules in effect on the date of the Notice of Closure or Determination Order control. Thus, the rules in effect April 1, 1991 apply. (See WCD Admin. Order 2-1991).

On review, claimant argues that based on her credible testimony that she regularly lifted weights in excess of 150 pounds, her at-injury job was "very heavy," rather than "heavy." Thus, she contends, the Referee should have calculated her permanent disability award using an adaptability factor of 7. We are not persuaded by claimant's argument.

The prior strength (physical demands) category for a worker's at-injury job is derived from the strength category assigned in the Dictionary of Occupational Titles (DOT) for the worker's at-injury job. Former OAR 436-35-270(3)(h). The DOT job title most accurately reflecting claimant's at-injury job is Resaw Operator (DOT 667.682-058). The DOT identifies that job as being in the heavy category. Because claimant is now limited to performing sedentary work, the adaptability value is 6, as found by the Appellate Unit and the Referee. Former OAR 436-35-310(3); see Robin G. Whitfield, 44 Van Natta 2128 (1992).

ORDER

The Referee's order dated June 24, 1992 is affirmed.

In the Matter of the Compensation of
**RANDALL L. HENDRICKSON, Claimant**
WCB Case No. 92-02826
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Livesley's order that set aside its partial denial of temporary disability benefits. Claimant cross-requests review of those portions of the order that declined to assess attorney fees: (1) for prevailing over the partial denial of temporary disability benefits; and (2) for an alleged unreasonable denial. On review, the issues are temporary disability benefits and attorney fees.

We affirm and adopt the Referee's order with the following supplementation regarding the attorney fee issue.

Relying on Short v. SAIF, 305 Or 541 (1988), the Referee awarded an out-of-compensation fee for claimant's attorney's efforts regarding the temporary disability issue. See Esther C. Albertson, 44 Van Natta 523 (1992); Mona L. Allison, 43 Van Natta 1749 (1991). Claimant argues that he is entitled to an assessed attorney fee pursuant to ORS 656.386(1) for prevailing against the insurer's partial denial of temporary disability benefits. We agree with the Referee's decision to award an out-of-compensation fee.

According to the Supreme Court, "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether claimant's condition was caused by an industrial injury, [former] ORS 656.386(1) is not the applicable attorney fee statute[.]" Short v. SAIF, supra at 305 Or 545. We recently held (subsequent to the Referee's order) that the 1991 amendments to the statute do not affect prior case law regarding its applicability. Gloria J. Shelton, 44 Van Natta 2232 (1992). Because this case concerns claimant's entitlement to temporary total disability, and there is no dispute regarding the compensability of claimant's condition, we find that ORS 656.386(1) is not applicable and, therefore, cannot provide a basis for awarding an assessed attorney fee. Short v. SAIF, supra; Tom B. Fredrickson, 45 Van Natta 211 (1993).

Claimant also argues that he is entitled to an assessed attorney fee pursuant to ORS 656.382(1) because, he asserts, the insurer's failure to pay temporary disability benefits was unreasonable. We disagree.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). Based on the information provided by claimant in his recorded statement, we find that the insurer had a legitimate doubt as to whether claimant was in the work force at the time of his compensable worsening and thus entitled to temporary disability benefits. (Ex. 16). Therefore, we agree with the Referee that the insurer's partial denial and failure to pay time loss was not unreasonable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 temporary disability issue 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.

In the Matter of the Compensation of
**DIANE M. SHIPLER, Claimant**
WCB Case No. 91-15210
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Menashe's order that: (1) set aside its partial denial of claimant's claim for a current low back condition; and (2) set aside a Determination Order and an Order on Reconsideration as "premature." Claimant cross-requests review, contending that the Referee erred regarding attorney fees, the Determination Order and the Order on Reconsideration. In her brief, claimant requests that we rate her permanent disability or remand for that purpose. In its brief, the employer requests authorization to offset overpaid temporary disability benefits. On review, the issues are compensability and, if claim closure was proper, extent of unscheduled permanent disability or remand, offset and attorney fees. We deny the motion to remand, reverse in part, affirm in part and authorize offset of overpaid temporary disability benefits.

## FINDINGS OF FACT

On April 9, 1991, claimant suffered a compensable lumbosacral contusion and strain. She was hospitalized after the injury until April 15, 1991 and treated conservatively thereafter.

On June 28, 1991, claimant was examined by a panel of physicians at Northwest Pain Center, including Dr. Seres. On August 14, 1991, claimant was examined by Drs. Fuller and Peterson of Impartial Medical Opinions, Inc. Dr. Crawford, treating physician, last examined claimant on August 19, 1991.

On October 4, 1991, the employer denied claimant's current low back condition.

An October 28, 1991 Determination Order found claimant medically stationary as of August 14, 1991 and awarded temporary but not permanent disability benefits. A January 30, 1992 Order on Reconsideration affirmed the Determination Order in all respects.

Claimant's degenerative arthritis at L5-S1, left ankle post-traumatic arthritis, postural hyperlordosis and obesity conditions preexisted her 1991 low back injury at work. These conditions caused no low back symptoms or disability prior to the April 1991 work injury.

## FINDINGS OF ULTIMATE FACT

Claimant's preexisting degenerative arthritis at L5-S1, left ankle post-traumatic arthritis, postural hyperlordosis and obesity conditions preexisted her April 9, 1991 lumbosacral contusion and strain at work and combined with that injury, resulting in claimant's subsequent disability and need for medical services for her low back.

Claimant's compensable injury remained the major contributing cause of her disability and/or need for medical services for her low back on October 4, 1991.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The medical evidence indicates that claimant's obesity, postural hyperlordosis, degenerative disc disease and left ankle arthritic condition preexisted her work injury. There is no evidence that these conditions resulted in low back disability or treatment prior to the April 1991 fall at work. On the other hand, it is undisputed that the above preexisting conditions prolonged claimant's recovery from her work injury. (See Exs. 39-11-13, 39-23, 39-30-31; see also Exs. 7-12, 13-2-3, 21, 25-6-7, 34-5). Consequently, to establish entitlement to compensation for her resulting low back condition, claimant must prove that the work injury is and remains the major contributing cause of her disability and/or

need for treatment for her low back. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Because the causation issue is a complex medical question, its resolution turns largely on our analysis of the 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). In evaluating the medical evidence, we rely on those opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

The employer does not dispute that claimant's low back condition was compensable from the date of her injury until August 14, 1991, the date of Fuller and Peterson's examination. (See Ex. 25). However, the employer does contend that, as of August 14, 1991, claimant's compensable injury was no longer the major contributing cause of her ongoing low back problems. We disagree.

After their August 15, 1991 examination of claimant, Fuller and Peterson opined that the "chronicity of [claimant's] low back pain complaints are [sic] due to a combination of obesity, postural hyperlordosis, preexisting degenerative changes in the lumbar spine and psychosocial factors." In their view, the April 1991 injury "has had adequate time to resolve." Thus, although Fuller and Peterson felt that the injury initially caused claimant's need for low back treatment, they concluded that it was not the major cause of claimant's low back problems on August 14, 1991. (Ex. 25-6-7).

Dr. Seres, Director of the Northwest Pain Center, agreed that a person without claimant's preexisting hyperlordosis and degenerative changes would probably have recovered more quickly from this injury. However, Seres' opinion supports our finding that the work injury remains the major reason for claimant's continuing low back problems.

Seres explained that the work injury caused structural damage to the soft tissues surrounding the diseased joints, when those tissues are already under stress because of claimant's weight and "sway back." The injury irritated the soft tissues and facet joints without doing further damage to the joints and discs themselves. Her symptoms are caused by this irritation, rather then by the preexisting pathologies. Furthermore, at the time of the denial and as of the hearing, the "main reason" claimant continued to have symptoms is the soft tissue irritation caused by the work injury. The preexisting pathologies remain as they were before the injury. They have not progressed. In fact, nothing has changed since the June 1991 work injury. The preexisting pathologies have delayed claimant's recovery, and to that extent, they are a factor. However, it is still the soft tissue work injury that is the cause of claimant's pain and, it is the soft tissue work injury from which claimant has not recovered. Therefore, the work injury remains the "main reason" for claimant's symptoms.

Fuller and Peterson's opinion differs from Seres' only insofar as Seres believes that claimant's injury remains the main cause of her low back problems, while Fuller and Peterson believe that the injury stopped being the major contributing cause because it should have resolved. Seres' opinion is more persuasive, because it is well-reasoned (rather than conclusory) and considers claimant's particular situation (rather than relying on generalized expectations). See Somers v. SAIF, supra; Vernon D. Feagins, 44 Van Natta 1235, 1236 (1992). Accordingly, based on Seres' opinion, we conclude that claimant has carried her burden of proving that her work injury remains the major contributing cause of her disability and need for treatment for her low back. Thus, the claim is compensable. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

Propriety of claim closure/Extent

The Referee set aside the October 28, 1991 Determination Order and the January 30, 1992 Order on Reconsideration (which awarded no permanent disability compensation), stating that these orders were premature. In reaching this result, the Referee reasoned that, because the Evaluation Division failed to consider claimant's then-current condition, there has been no administrative closure of the accepted claim. We disagree.

The Determination Order correctly referred to claimant's April 9, 1991 date of injury and awarded temporary disability compensation through claimant's August 14, 1991 medically stationary date. The evaluator's worksheet indicates that permanent disability benefits were not awarded, based on Fuller and Peterson's opinion and Dr. Crawford's concurrence. (Ex. 33-2; see Exs. 25 & 31). In addition, the order provided: "This is not a determination of any denials issued by the insurer." (Ex. 33-1). The Reconsideration Order affirmed the Determination Order in all respects.

On this record, we have no reason to believe that Evaluation Division failed to consider claimant's compensable condition in closing her claim. See Nellie M. Ledbetter, 43 Van Natta 570 (1991). Moreover, because claimant's medically stationary status is conceded by claimant, we conclude that the Determination Order properly closed the claim. In any case, upon claimant's request for hearing from the October 28, 1991 Determination Order and January 30, 1992 Order on Reconsideration, the Referee had authority to determine all matters concerning claimant's claim, including the extent of disability stemming from the compensable injury. ORS 656.283 & 656.708; See Hutson v. Precision Construction, 116 Or App 10 (1992); Nellie M. Ledbetter, supra at 572.

Because the Determination Order properly closed the claim, we next consider claimant's alternative requests for remand or review of the Appellate Unit's failure to award permanent disability on reconsideration of the Determination Order.

We may remand for further evidence if we determine that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In this case, claimant presents no argument concerning the sufficiency of the record regarding her alleged permanent disability. Moreover, we are not persuaded that this case has been improperly, incompletely or insufficiently developed. Accordingly, claimant's motion to remand is denied.

Turning to the merits of the permanent disability issue, we find that the opinion of Dr. Crawford, treating physician, fails to persuasively establish that any permanent disability which claimant may have is injury-related. (See Exs. 25 & 31). Accordingly, we agree with the Appellate Unit that claimant does not have ratable permanent injury-related impairment. See ORS 656.214(2). Thus, on de novo review, we conclude that claimant has not proven entitlement to permanent disability compensation. Accordingly, we reinstate and affirm the Determination Order and the Order on Reconsideration.

In addition, based on the parties' agreement concerning the employer's overpayment of temporary disability benefits (see Tr. 3-4), the employer is authorized to offset the agreed amount ($2,212.70) against any future awards of permanent disability compensation. See Steve E. Maywood, 44 Van Natta 1199 (1992).

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 compensability issue is $1,000, 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. Finally, after considering the factors set forth in OAR 438-15-010(4), we affirm the Referee's attorney fee award.

## ORDER

The Referee's order dated April 10, 1992 is reversed in part and affirmed in part. That portion of the order that set aside the October 28, 1991 Determination Order and the January 30, 1992 Order on Reconsideration are reversed and those orders are reinstated and affirmed. The employer is authorized to offset overpaid temporary disability benefits of $2,212.70 against any future awards of permanent disability. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1000, payable by the self-insured employer.

In the Matter of the Compensation of
**LEWIS YOCK, Deceased**
WCB Case No. 92-02494
ORDER ON REVIEW
Scheminske & Lyons, Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant (decedent's alleged beneficiary) requests review of Referee Neal's order that: (1) upheld the insurer's denial of claimant's claim for survivor's benefits; (2) declined to award a penalty for an allegedly unreasonable denial; and (2) declined to award a penalty for an allegedly unreasonable failure to provide discovery. The self-insured employer moves to strike claimant's reply brief, on the ground that the reply brief raises a new issue. On review, the issues are motion to strike, survivor's benefits and penalties. We deny the motion to strike, and affirm on the remaining issues.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to strike

The employer moves to strike claimant's reply brief on the ground that claimant has raised an issue for the first time in her reply brief. Specifically, claimant's reply brief argues that, pursuant to Satterfield v. Compensation Dept., 1 Or App 524 (1970), it is the employer's burden to prove that claimant lived in a state of abandonment and that she did not receive support from the decedent.

We do not agree that claimant has raised a new issue or theory in her reply brief. The primary issue in this case involves claimant's entitlement to survivor's benefits, which necessarily includes a burden of proof issue. Claimant's reply brief merely provides an additional argument in support of her position on the underlying "issue." Under the circumstances, we do not find that it is fundamentally unfair to the employer to allow claimant to cite to "burden of proof" caselaw in her reply brief. See e.g. Kevin C. O'Brien, 44 Van Natta 2587, on recon 45 Van Natta 97 (1993). The employer's motion to strike is, therefore, denied.

### Survivor's benefits

We affirm and adopt the Referee on the issue of survivor's benefits.

### Allegedly unreasonable denial

We affirm and adopt the Referee on the issue of entitlement to a penalty for an allegedly unreasonable denial.

### Allegedly unreasonable failure to provide discovery

We affirm and adopt the Referee on the issue of entitlement to a penalty for an allegedly unreasonable failure to provide discovery.

## ORDER

The Referee's order dated June 22, 1992 is affirmed.

In the Matter of the Compensation of
**THOMAS D. OLIVE, Claimant**
WCB Case No. C3-00672
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

On March 15, 1993, 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 disapprove 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).

Here, the proposed agreement purports to release claimant's future rights to workers' compensation benefits, except for medical services, payable under his workers' compensation claim. However, on page 3, the agreement provides that "the proceeds of the agreed-upon settlement shall fund improvements to (claimant's) van and house necessarily related to (claimant's) injuries." The Board has previously held that such improvements and modifications are medical services, and any such limitation on claimant's right to medical services exceeds the bounds of ORS 656.236(1) and the rules promulgated thereunder. See Maria J. Orejal, 43 Van Natta 1731 (1991); Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990). Therefore, because the offensive portion of the disposition agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. See Karen A. Vearrier, 42 Van Natta 2071 (1990).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by 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 which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**NELSON E. THOMPSON, Claimant**
WCB Case No. 91-05716
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Claimant requests reconsideration of our February 22, 1993 Order on Review that reversed a Referee's order which set aside the SAIF Corporation's denial of claimant's current low back condition.

On reconsideration, claimant first contends that we should have found that his spondylolisthesis condition is part of his original compensable claim. Claimant contends that regardless of the fact that his accepted injury was a low back strain, he has been awarded 20 percent unscheduled permanent disability for his condition, including the spondylolisthesis condition.

Claimant argues that in a prior Opinion and Order, a referee relied upon the medical reports of claimant's treating physician, Dr. McFie, who had reported that claimant's injury was causing a deterioration of his already present spondylolisthesis. Claimant argues that because the Referee proceeded to award permanent disability, it is the law of the case that the spondylolisthesis condition is a part of the compensable injury and it, therefore, cannot be considered a preexisting condition.

We do not agree with claimant's contentions. First, we find no specific findings or conclusion by the prior referee that establishes that compensability of claimant's spondylolisthesis condition was litigated or considered as part of the compensable claim. Furthermore, we have previously held that an award of permanent disability does not equate to acceptance of a claim. Gloria T. Olson, 44 Van Natta 2519 (1992). Accordingly, the fact that SAIF chose to pay claimant's permanent disability award following the prior referee's order, rather than appealing the order, does not mean that SAIF has accepted the spondylolisthesis condition. Therefore, we disagree with claimant's contention that the "law of the case" establishes that his preexisting condition is a compensable part of the claim.

Claimant next contends that we have misinterpreted Dr. Hubbard's opinion and that Dr. Hubbard agreed with Dr. Stringham that the industrial injury of 1989 was the major cause of claimant's current condition. Claimant also argues that we should not have discounted the opinion of Dr. Stringham.

We conclude that our prior order has adequately addressed both of these issues, and we therefore decline to further address them.

Accordingly, the request for reconsideration is granted and our February 22, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 22, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MICHAEL R. WICKSTROM, Claimant**
WCB Case No. 91-11489
ORDER ON REVIEW
Max Rae, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Myers' order that dismissed his request for hearing after setting aside an Order on Reconsideration as invalid on the basis that the Director failed to appoint a medical arbiter prior to issuance of the Order on Reconsideration. On review, the issue is jurisdiction. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

On April 26, 1991, claimant requested reconsideration of the Notice of Closure, raising disagreement with the impairment findings used in the Notice of Closure.

## CONCLUSIONS OF LAW AND OPINION

The Referee declined to admit a medical arbiter's report because it was offered for the first time at hearing for the purpose of evaluating claimant's impairment. The parties agreed to waive any defects in the reconsideration process and asked the Referee to rely on the arbiter's report. The Referee concluded that he was prevented from considering the arbiter's report by ORS 656.268(7), which provides that the findings of the medical arbiter must be submitted to the Department for reconsideration. The Referee then proceeded to find the Order on Reconsideration invalid because the Director had failed to comply with the statutory provisions of ORS 656.268(7). Subsequent to the Referee's order, this Board issued Olga I. Soto, 42 Van Natta 697, recon den 44 Van Natta 1609 (1992), which concluded that where, as here, the Director does not comply with that mandatory procedure, and one of the parties objects to the order issued, the Order on Reconsideration is invalid.

Here, both parties purport to waive any defects in the Order on Reconsideration. The defect is the Director's failure to consider the arbiter's report which issued after the Order on Reconsideration. Yet, both parties continue to request that the arbiter's report be considered on review. The admission of the medical arbiter's report is inconsistent with the waiver of an objection to the impairment findings. ORS 656.268(7) makes the appointment of a medical arbiter conditional on claimant's objection to impairment findings. That is, a medical arbiter is not appointed, nor is a medical arbiter report issued, unless claimant objects to his attending physician's impairment findings. Therefore, we conclude that by seeking the admission of the medical arbiter report, claimant maintained an objection to the impairment findings and did not waive his right to a medical arbiter. See Daniel Crawford, 45 Van Natta 460 (1993).

Under these circumstances, we find that the Director failed to follow the mandatory reconsideration procedure in ORS 656.268(7) by issuing the Order on Reconsideration without considering the medical arbiter report. Because we have found that claimant did not waive his right to a medical arbiter, we conclude that the Order on Reconsideration is invalid and that jurisdiction over this matter still lies with the Director.[1] See Olga I. Soto, supra.

Claimant argues in the alternative that, if the arbiter's report was correctly excluded by the Referee, we should remand the case to the Director to remedy its defective Order on Reconsideration and to adopt temporary rules under ORS 656.726(3)(f)(C) to accommodate claimant's 50 percent loss of chest expansion not covered by the standards for rating permanent disability.

Subsequent to the issuance of the Referee's order, we concluded that the Hearings Division and the Board lack authority to remand to the Director for a finding that a claimant's disability is not addressed by the standards and for adoption of temporary rules to accommodate such an impairment. See Gary D. Gallino, 44 Van Natta 2506 (1992). We also concluded that there is no authority for remanding a case to the Department for the issuance of a valid Order on Reconsideration. See Mickey L. Platz, 44 Van Natta 1056 (1992). Rather, because the Order on Reconsideration is invalid, jurisdiction of this dispute remained with the Department. Id.

ORDER

The Referee's order dated December 23, 1991, as reconsidered January 9, 1992, is affirmed.

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[1] ORS 656.268(6)(a) was amended in 1991 to allow the admission of a medical arbiter report into evidence at hearing, if the report was not prepared in time for the reconsideration proceedings. However, that amendment only applies to requests for reconsideration made after October 1, 1991. See Or Laws 1991, ch 502, § 1. Because claimant's request for reconsideration was made before that date, the amendment does not apply here.

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In the Matter of the Compensation of
**HELEN L. DODGE, Claimant**
Own Motion No. 92-0189M
SECOND OWN MOTION ORDER OF ABATEMENT
Coons & Cole, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests that we abate and reconsider our February 26, 1993 Own Motion Order on Reconsideration. With its request, SAIF has submitted a copy of its January 29, 1993 partial denial which denies claimant's current condition based on the lack of a causal relationship between claimant's compensable injury and her current condition. This is our first notice of SAIF's denial.

In response to SAIF's motion, we find the following summary of this claim's procedural background to be instructive. On April 8, 1992, claimant's counsel sought Own Motion relief. Following a series of Board requests for information, claimant's counsel responded that SAIF had refused to authorize palliative care resulting in claimant's hospitalization. On August 13, 1992, the Board denied relief concluding that the record did not establish a relationship between claimant's need for hospitalization and her compensable injury.

On August 17, 1992, claimant's counsel argued that the claim was compensable because SAIF had not issued a denial. Counsel also stated that, had SAIF contested the appropriateness of the treatment, claimant would have requested Director review under ORS 656.327. Treating this notification as a request for reconsideration, we issued a September 11, 1992 Order of Abatement.

On September 22, 1992, SAIF announced that it was scheduling claimant for an October 10, 1992 independent medical examination. If claimant's condition was determined to be compensable, SAIF further contended that the hospitalization was excessive and unnecessary treatment.

On December 17, 1992, Board staff counsel requested that, within 14 days from the date of the letter, SAIF provide either a copy of its formal denial or a copy of a request for Director's review. In the absence of either action, the parties were notified that the Board would consider reopening claimant's claim contingent upon the resolution of the parties' dispute.

When no response from SAIF was forthcoming, the Board issued a February 26, 1993 Own Motion Order on Reconsideration. Declining to leave the parties in a perpetual state of limbo, particularly when a practical solution was available, we found it appropriate to authorize the payment of temporary disability compensation on a contingent basis. In the event that it was subsequently resolved that claimant's hospitalization was appropriate and causally related to her compensable injury, we authorized the payment of temporary disability compensation beginning from the date of hospitalization. In reaching this conclusion, we emphasized that as long as the parties' dispute remained unresolved, no temporary disability compensation was authorized.

In response to our February 26, 1993 Order, SAIF has moved for abatement and reconsideration. Notwithstanding our staff counsel's prior letters concerning a possible denial, SAIF did not provide a copy of its January 29, 1993 denial until its motion for abatement and reconsideration of our February 26, 1993 order. Had SAIF timely responded to our prior requests for information, our February 26, 1993 "contingent" order would not have issued. Moreover, since the causal relationship between claimant' compensable injury and her hospitalization is now formally in dispute (and thereby unresolved), no temporary disability is due as a result of our "contingent" order.

In any event, in the hope of clarifying the parties' respective positions regarding this ongoing dispute, we abate and withdraw our February 26, 1993 order. Claimant is requested to file a response within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of Complying Status of
**MACH II, Employer**
WCB Case No. 90-16386
ORDER ON REVIEW
Donald Dickerson, Attorney
Saif Legal Department, Attorney
Coons, et al., Attorneys

Reviewed by Board Members Neidig and Brazeau.

Mach-II, an alleged noncomplying employer, requests review of Referee McWilliams' order that: (1) affirmed a Director's proposed order finding Mach II to be a noncomplying employer; (2) upheld the SAIF Corporation's acceptance of claimant's left wrist and arm claim on Mach II's behalf; (3) declined Mach II's motion to continue the hearing; and (4) denied Mach II's request to admit into evidence three unsworn letters from businesses and individuals who were not present to testify at the hearing. With its appellant's brief, Mach II has submitted several documents most of which were generated after the record closed. Objecting to this submission, claimant has moved to strike Mach II's reference to these documents. We treat Mach II's submission as a motion to remand to the Referee for the taking of additional evidence.

On review, Mach II contends that: (1) the Referee's order is invalid because it was not issued within 30 days of closure of the record; (2) the Referee lacked jurisdiction to issue an amended order since jurisdiction had vested with the Board prior to issuance of the amended order; (3) claimant is not a subject worker for Mach II; (4) claimant's injury is not compensable; (5) the Referee should have granted Mach II's motion to continue the hearing; (6) the Referee erred in excluding the aforementioned unsworn statements; and (7) the submitted documents should be considered.

We affirm and adopt the Referee's order as modified and supplemented.

To begin, Mach II filed its request for Board review of the Referee's July 8, 1992 order prior to the issuance of the Referee's amended July 13, 1992 order. Under such circumstances, the Referee lacked authority to issue the amended order. Ramey S. Johnson, 40 Van Natta 370 (1988). Considering the invalidity of the Referee's amended order, our review solely pertains to the Referee's July 8, 1992 order.

Secondly, Mach-II seeks a re-hearing, contending that the Referee's July 8, 1992 order is invalid because it issued more than 30 days after the February 24, 1992 closure of the record. We disagree. Although a referee's failure to comply with the requirement in ORS 656.289(1) to issue an order within 30 days of the hearing may subject a referee to mandamus, such a failure does not deprive the referee of the power to act. Lyday v. Liberty Northwest Insurance Corporation, 115 Or App 668 (1992).

We turn to Mach II's objections to the Referee's continuance and evidentiary rulings. Although the Referee's rejection of Mach-II's motion to continue the hearing is raised as an issue, Mach-II does not provide any argument describing why the Referee's ruling was erroneous. This ruling was made in conjunction with the Referee's exclusion of Exhibits 9a, 9b, and 9c, which were letters and written statements from businesses and individuals regarding prior events/conversations with claimant and Mr. and Mrs. Moch (doing business as Mach II). None of the signators to these statements/letters were present to testify.

Disagreeing with Mach II's contention that the letters were admissible under the "business correspondence" exception to the hearsay rule, the Referee excluded the letters. In addition, the Referee denied Mach II's motion to continue the hearing to permit the signators to testify. Noting that a hearing had previously been postponed on four separate occasions at Mach II's request, the Referee concluded that Mach II had not established extraordinary circumstances beyond its control to justify the continuance. See OAR 438-06-091.

After conducting our review, we conclude that it was not an abuse of discretion for the Referee to reject the unsworn statements from the individuals who were not present to testify. Likewise, we do not consider the Referee's decision to reject the continuance motion to be an abuse of discretion.

Finally, Mach II has included copies of vocational and medical reports (most of which were generated subsequent to closure of this record), which discuss claimant's physical complaints, as well as his medical and work histories. Asserting that statements attributable to claimant are at variance with several portions of his testimony, Mach II argues that these materials further confirm its contention that claimant lacks credibility. Inasmuch as these submissions are not part of the record developed before the Referee, we treat these documents 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. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be 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. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986).

We consider the proffered evidence only for the purposes of determining whether remand is appropriate. In light of the manner in which we are considering Mach II's submission, we deny claimant's motion to strike.

Many of the statements attributable to claimant in the submitted materials pertain to an alleged causal relationship between claimant's current left elbow and tooth conditions to his work injury. Yet, the issue for our determination pertains to whether claimant suffered an injury while performing his work activities which required medical treatment or resulted in disability. ORS 656.005(7). Since the statements regarding a potential relationship between the aforementioned conditions and the work injury are arising from SAIF's processing of the claim on behalf of Mach II, such issues are within the statutory province of SAIF to investigate whether those conditions will be accepted or denied. ORS 656.054(1). Inasmuch as our review does not concern the processing of claimant's claim in response to the appealed Referee's order, Mach II's submission of the statements regarding claimant's "post-order" conditions do not justify remand.

The remainder of the submitted materials pertain to medical and vocational reports which suggest a medical and work history at variance with claimant's testimony and prior histories. The record developed at hearing is replete with written and testimonial evidence regarding claimant's relationship with Mach II, events surrounding the work incident, and claimant's complaints.

In light of such circumstances, we do not consider the record to be improperly, incompletely, or otherwise insufficiently developed. See ORS 656.295(5). Accordingly, we deny the motion to remand.

Inasmuch as we have found that the compensation awarded by the Referee's order should not be disallowed or reduced, claimant 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 assessed attorney fee for claimant's counsel's services on review is $500, to be paid by the SAIF Corporation, on behalf of the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate arguments), the complexity of the issues, and the value of the interest involved.

## ORDER

The Referee's order dated July 8, 1992 is affirmed. For services on Board review, claimant's attorney is awarded $500, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

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March 25, 1993 Cite as 45 Van Natta 528 (1993)

In the Matter of the Compensation of
**BRENDA G. CHANEY, Claimant**
WCB Case No. 92-05558
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The self-insured employer requests review of those portions of Referee Schultz' order that: (1) found that claimant was entitled to temporary disability benefits; and (2) ordered payment of temporary disability benefits until claim closure. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty for an allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are temporary disability benefits and penalties. We affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On December 10, 1992, the Board affirmed Referee Nichols' order in WCB Case Nos. 91-11365 and 91-17485.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Benefits

We adopt the Referee's findings and conclusions concerning the merits of the temporary disability benefits issue. However, we agree with the employer that the order is overly broad.

Accordingly, that portion of the order which directed the employer to pay temporary disability benefits until claim closure is modified. Instead, the employer is directed to pay temporary disability benefits according to law.

Penalties

We adopt the Referee's conclusions and reasoning with the following supplementation.

At the time of the employer's failure to pay temporary disability benefits, claimant was not working. Rather, she was enrolled in college. While we affirm the Referee's holding that claimant remained in the work force, we recognize that the employer had a legitimate doubt as to whether claimant was in the work force at the time of her compensable worsening.

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 temporary disability benefits issue is $1,100, 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 her attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 27, 1992 is modified in part and affirmed in part. That portion of the Referee's order which directed the self-insured employer to pay temporary disability benefits until claim closure is modified. The employer is directed to pay temporary disability benefits according to law. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,100, payable by the self-insured employer.

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March 25, 1993 Cite as 45 Van Natta 529 (1993)

In the Matter of the Compensation of
**FRANK DAVILA, Claimant**
WCB Case No. 92-00184
ORDER ON REVIEW
Bryant, et al., Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Garaventa's order that declined to award a penalty for the SAIF Corporation's allegedly unreasonable denial. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF's January 2, 1992 denial of claimant's claim for a November 8, 1991 shoulder injury was not unreasonable. She reasoned that, because SAIF's investigation revealed that claimant had a noncompensable motor vehicle accident (MVA) shortly before his work injury and claimant's former attorney impeded the investigation (by preventing SAIF from interviewing claimant concerning the MVA), the MVA was not sufficiently explained away until hearing. Thus, the Referee concluded that SAIF had a legitimate doubt as to its liability until hearing. We disagree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A carrier's

"refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc., v. Porras, 103 Or App (1990).

In this case, there is no evidence regarding the off-work MVA prior to the hearing transcript. Furthermore, SAIF's written denial states:

> "There is insufficient evidence to establish the compensability of your claim because your pre-exiting [sic] condition is the major contributing cause of your disability and need for medical treatment. Your x rays show that you have a chronic impingement problem with your right shoulder." (Ex. 8).

Considering the above plain language, we do not find that SAIF's denial was based on an asserted contribution to claimant's rotator cuff tear by the noncompensable MVA. We next consider whether the denial was supported by evidence indicating a causal contribution from a noncompensable impingement syndrome.

Following claimant's November 8, 1991 work injury, Dr. Hakala's impression was "R/O torn rotator cuff." (Ex. 3). Hakala referred claimant to Dr. Wigle, who diagnosed a "full thickness rotator cuff tear." (Ex. 4-2). Although Wigle noted that claimant's "x-rays show some scallopining of the greater tuberosity consistent with impingement" and "an overlying osteophyte off his acromion," (id.), there is no indication that either of these findings contributed to claimant's post-injury symptoms or his need for medical services. On the contrary, Wigle's "clinical impression" was that claimant required surgery specifically to repair the rotator cuff tear. (Id). This opinion is uncontroverted. On this evidence, we find that SAIF's denial, which was based on an asserted contribution by claimant's impingement condition, was unsupported when it issued. Thus, SAIF has not proven that it had a legitimate doubt regarding its liability when it denied claimant's injury claim. Under these circumstances, the denial was unreasonable and a penalty of 25 percent is appropriate.

## ORDER

The Referee's order dated May 4, 1992 is reversed in part and affirmed in part. That portion of the order that denied claimant's request for a penalty is reversed. Claimant is awarded a penalty equal to 25 percent of amounts due at hearing as a result of the Referee's compensability decision, with one-half to be paid to claimant's attorney. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**WALTER T. DRISCOLL, Claimant**
WCB Case No. 92-01106
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration which found that claimant's left elbow injury claim was properly classified as nondisabling. On review, the issue is claim classification. We vacate.

## FINDINGS OF FACT

Claimant filed an injury claim on March 29, 1991. On May 30, 1991, the insurer accepted a nondisabling "left forearm contusion." (Ex. 8). Claimant requested reclassification. The insurer declined to change the classification to disabling. In a July 25, 1991 Determination Order, the Department of Insurance and Finance (Department) determined that the claim should remain classified as nondisabling.

Claimant requested a hearing. An earlier referee dismissed this request, reasoning that claimant was first required to seek reconsideration of the Determination Order. Thereafter, claimant requested reconsideration. In a January 21, 1992 Order on Reconsideration, the Department affirmed the Determination Order. This case is claimant's hearing request from that reconsideration order.

CONCLUSIONS OF LAW AND OPINION

On March 3, 1993, the Board reversed the earlier referee's order. Walter T. Driscoll, 45 Van Natta 391 (1993). Reasoning that it was not necessary to first seek reconsideration of a classification order, the Board proceeded to review the classification request. The Board affirmed the July 25, 1991 Determination Order denying reclassification.

In light of the Board's resolution of the earlier case, it follows that the claim classification issue presently raised in this case is controlled by the earlier decision. Moreover, considering our conclusion that the earlier referee had jurisdiction to consider the classification issue, it further follows that the Department's reconsideration order was invalid. In any event, the law of the case is that claimant's claim was properly classified as nondisabling. Accordingly, Referee Neal's order addressing this matter is vacated and claimant's request for hearing is dismissed.

ORDER

The Referee's order dated April 21, 1992, as amended April 22, 1992, is vacated. Claimant's request for hearing is dismissed.

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March 25, 1993 Cite as 45 Van Natta 531 (1993)

In the Matter of the Compensation of
**GREGORY L. FORSYTH, Claimant**
WCB Case No. 92-01357
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of Referee Mills' order that: (1) upheld the insurer's denial of his claim for his current cervical condition; and (2) failed to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties, and attorney fees. We affirm.

CONCLUSIONS OF LAW AND OPINION

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

The Referee correctly determined that the propriety of the insurer's denial is governed by 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."

The Referee concluded that because, at best, the relative contribution of the compensable injury and the preexisting condition to claimant's current condition were equal, the injury is not the major contributing cause of claimant's current disability or need for treatment. Therefore, the Referee upheld the insurer's denial of claimant's current cervical condition.

Claimant contends that his September 1991 industrial injury is the major contributing cause of his cervical disability and need for treatment. We are not persuaded that claimant's industrial injury is, or ever was, the major contributing cause of his resultant disability.

In Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), the Oregon Court of Appeals explained that, "under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment." 117 Or App at 412. (Emphasis in original.)

For the reasons expressed by the Referee, the medical evidence does not establish that claimant's September 1991 industrial injury, when compared with his preexisting degenerative condition, is or ever was, the major contributing cause of his cervical disability and need for medical treatment. Because claimant's resultant cervical disability is not compensable, we affirm the Referee's upholding of the insurer's denial. See ORS 656.005(7)(a)(B). Moreover, because the insurer's denial was not unreasonable, the Referee also did not err in failing to award attorney fees and penalties.

ORDER

The Referee's order dated July 8, 1992, is affirmed.

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March 25, 1993 Cite as 45 Van Natta 532 (1993)

In the Matter of the Compensation of
**JOHN R. HEATH, Claimant**
WCB Case Nos. 91-14829 & 91-02296
ORDER OF ABATEMENT
Bottini, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

On March 12, 1993, we declined to award claimant additional temporary disability benefits beyond January 3, 1991. Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), we reasoned that, because we had found claimant to be medically stationary as of January 3, 1991, claimant's "substantive" entitlement to temporary disability benefits ended as of that date. Claimant has petitioned the Court of Appeals for judicial review of our order. Nevertheless, since the 30-day statutory period under ORS 656.295(8) has not expired, we retain authority to withdraw our March 12, 1993 order, notwithstanding claimant's appeal. SAIF v. Fisher, 100 Or App 288 (1990).

It has come to our attention that the result in this case might conflict with our decision in Glen D. Roles, 45 Van Natta 282 (1993), on recon 45 Van Natta 488 (1993). In Roles, the referee increased temporary disability awards granted by determination orders. The insurer requested Board review and refused to pay the additional awards pending review. On Board review, we reversed the referee's awards. Nevertheless, pursuant to former ORS 656.313, we subsequently ordered the insurer to pay temporary disability benefits awarded by the referee.

In Roles, we distinguished Seiber on the basis that, whereas the temporary disability benefits at issue in Seiber were "procedural" in nature, the temporary disability benefits in Roles were compensation to which claimant was substantively entitled under former ORS 656.313 pending the insurer's appeal from the referee's order. 45 Van Natta at 284.

In light of Roles, we withdraw our March 12, 1993 order for reconsideration. The parties are requested to submit supplemental briefs addressing the applicability of Roles to this case. For the parties' convenience, a copy of the recent Roles' decisions are enclosed with each respective counsel's copy of this order.

To be considered, the supplemental briefs shall be submitted within 14 days from the date of this order. Upon receipt of those briefs, or expiration of the aforementioned 14-day period, we shall proceed with our review of this matter.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**HUBERT W. JOHNSON, Claimant**
WCB Case Nos. 91-08922 & 91-06549
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

CNA Insurance Company (CNA) requests review of Referee Brazeau's order that: (1) set aside its "new injury" denial of claimant's injury claim for C5-6 and C6-7 herniated disc conditions; and (2) upheld Argonaut Insurance Company's (Argonaut) denial of claimant's aggravation claim for the same conditions. On review, the issues are compensability and responsibility. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## FINDINGS OF ULTIMATE FACT

Claimant's January 8, 1991 work injury with CNA's insured is the major contributing cause of his disability and need for treatment for a C5-6 and C6-7 herniated disc conditions.

The existence of claimant's C5-6 and C6-7 disc conditions is established by medical evidence supported by objective findings, including motor deficits and diminished reflexes.

## CONCLUSIONS OF LAW AND OPINION

The Referee followed our decision in Bahman M. Nazari, 43 Van Natta 2368 (1991), and applied the material contributing cause standard to resolve the compensability issue. Therefore, the Referee concluded that CNA was responsible for claimant's condition. Since the Referee's order, the court has interpreted ORS 656.005(7)(a)(B) to require the major contributing cause standard of proof in cases where a preexisting disease or condition combines with a compensable injury to cause or prolong disability or a need for treatment. Tektronix v. Nazari, 117 Or App 409 (1992).

In this case, the medical evidence indicates that claimant's current back problems involve a degenerative cervical condition which preexisted the 1986 strain injury claim accepted by Argonaut. However, there is no evidence that, in accepting that claim, Argonaut accepted anything more than the claimed strain, (see Ex. 8), or, at most, a temporary symptomatic worsening of claimant's preexisting degenerative condition. See Boise Cascade Corp. v. Katzenbach, 104 Or App 732, 735 (1990), rev den 311 Or 261 (1991) (Employer's acceptance of a "strain" is not an acceptance of the worker's underlying condition); see Electric Mutual Liability Ins. Co. v. Automax, 113 Or App 531 (1992) (Where claim for shoulder and arm strain is accepted, Board must make findings to support its conclusion that employer thus accepted responsibility for claimant's subsequent claim for bilateral CTS).

Moreover, the persuasive medical evidence does not indicate that claimant's 1986 injury contributes to his current cervical disc condition. Thus, the claim does not involve "a condition that has been previously processed as part of a compensable claim." Smurfit v. DeRossett, 118 Or App 368 (1993). Under these circumstances responsibility is not at issue and ORS 656.308(1) does not apply to this case. The remaining question is whether claimant suffered a compensable injury in 1991. See Smurfit v. DeRossett, supra; John P. Lambert, 45 Van Natta 472 (1993); see also Sandra L. Schuchert, 44 Van Natta 722, 723 (1992); Beverly R. Tillery, 43 Van Natta 2470, 2472 (1991).

As we have stated, to prove that his current cervical condition is compensable, claimant must establish that his 1991 injury, rather than the preexisting condition, is the major contributing cause of his need for medical services. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

Due to the number of potential causes for claimant's current condition, the causation issue is a complex medical question which must be resolved by 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 evaluating causation, we generally defer to the opinion of a worker's treating physician,

absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). The opinion of a worker's treating surgeon is entitled to particular deference, due to that physician's unique "hands on" opportunity to observe the worker's condition. Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). In addition, we rely on those opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259 (1986).

In this case, medical opinions concerning causation are divided, with Dr. Tsai, treating neurosurgeon, and Dr. Rosenbaum, independent neurologist, providing the primary opposing opinions. Even considering claimant's recognized degenerative disease, Tsai concluded that the 1991 incident was the major contributing cause of claimant's need for cervical surgery following that incident. CNA argues that Dr. Tsai's opinion is not persuasive, contending that Tsai changed his opinion without explanation and that Tsai's conclusions are based on an inaccurate or incomplete history. We disagree.

At the outset, we note that Tsai examined claimant only once before performing surgery and Rosenbaum never examined claimant. In addition, it is clear that Tsai did not compare claimant's 1985 x-rays with those taken in 1991. However, as Rosenbaum explained, such a comparison would reveal only changes in bony abnormalities, not in discs. Considering Tsai's 1991 surgical findings, which confirmed herniation-related nerve compromise, we are not persuaded that Tsai's failure to compare x-rays diminishes the accuracy or completeness of his history.

CNA further contends that Tsai's history was incomplete because he was unaware that claimant's neck and shoulder symptoms worsened gradually between 1986 and 1991. Although Tsai does not acknowledge this fact, we do not find this omission to be a material defect in his history for the following reasons. First, Tsai did review claimant's treatment records following the 1986 cervical strain. (See Ex. 24). In so doing, Tsai noted that claimant sought treatment only once for neck or shoulder symptoms between December 1986 and January 1991. (Id. see Exs. 1-13; Tr. 63). Second, in forming his opinion concerning causation, Tsai expressly relied on findings indicating new neurological deficits which appeared after the January 1991 incident and the concurrent sudden increase in neck pain. Specifically, on January 18, 1991, Tsai found evidence of neurologic motor weakness, which he later explained was not present prior to the 1991 incident. (See Exs. 13-2; 24-3; 28-14). Based primarily on this new finding, Tsai recommended surgery. He further explained that delaying surgery was contraindicated, because of the risk that claimant's bicep might become paralyzed. (See Tr. 24). Tsai's reasoning in this regard is unchallenged.

Moreover, Tsai noted that pre-1991 weakness findings were reported by nonspecialists or involved diminished grip strength without lost reflexes, (see Ex. 4-2), rather than bicep/tricep weakness. Tsai and Rosenbaum acknowledged that nonspecialists' measurements and evaluation of weakness likely differ from those of neurologists. Consequently, considering the undisputed differences between claimant's prior and current strength findings, Tsai's explanation of the significance of these differences, and Rosenbaum's failure to address Tsai's reasoning in this regard, we are not persuaded by CNA's attack on the accuracy and completeness of Tsai's history.

CNA also contends that Tsai changed his opinion without explanation. It is true that Tsai initially related claimant's 1991 problems to the 1986 strain injury, without mentioning a 1991 incident. (See Ex. 13). However, at the time of that opinion, Dr. Martin had informed Tsai only that claimant recently "reaggravated" the 1986 problem. (See Ex. 28-32). On the other hand, after reviewing claimant's chart notes from 1977-1991, as well as claimant's detailed statement concerning the 1991 incident, (see Ex. 24-1), Tsai opined that claimant suffered a "significant aggravation" of his cervical pathology on January 8, 1991. (Ex. 24-3). Tsai explained that his initial opinion was based on the history he had at the time. (Ex. 28-9-10). Thus, the changed opinion is explained by new information. Moreover, Tsai's conclusion that the 1991 changes were significant, specifically indicating surgery, is uncontradicted. (See Ex. 28-12-15). Under these circumstances, we find Tsai's opinion to be well-reasoned and persuasive.

Based on Tsai's opinion, we find that the 1991 work incident is the major contributing cause of claimant's recent need for surgery. (See Ex. 28-28). In addition, we find that claimant's current cervical condition is established by medical evidence supported by objective findings, including motor deficits and diminished reflexes. (See Ex. 13-2). Accordingly, claimant's cervical condition is compensable as a new injury, for which CNA is responsible.

Claimant's counsel is entitled to an assessed attorney fee for services on review, payable by CNA. 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 is $900, to be paid by CNA. 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 June 26, 1992 is affirmed. For services on review, claimant's attorney is awarded an attorney fee of $900, payable by CNA Insurance Company.

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In the Matter of the Compensation of
**WALTER JONES, JR., Claimant**
WCB Case No. 90-07999
ORDER ON REMAND (REMANDING)
Malagon, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Jones v. Sherrell Chevrolet, 117 Or App 490 (1992). The court has reversed our prior order which adopted a Referee's order that had held that claimant was no longer entitled to permanent total disability (PTD). Reasoning that our decision had turned on whether part-time work as an advertising sales representative constituted a "gainful occupation" under ORS 656.206(1)(a), the court has remanded for reconsideration in light of Tee v. Albertson's, Inc., 314 Or 633 (1992).

The Supreme Court has defined "gainful occupation" under ORS 656.206(1)(a) as "profitable remuneration." Tee v. Albertson's, Inc., supra, 314 Or at 643. Taking its lead from the Tee holding, the Court of Appeals has remanded this case for reconsideration because "the Board is the appropriate body to apply the meaning of 'gainful occupation' under the facts of this case in performing its factfinding function * * *." Jones v. Sherrell Chevrolet, supra, 117 Or App at 493.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). 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 clearly be 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. Olson, 37 Van Natta 1054 (1986), aff'd mem, 80 Or App 152 (1986).

On remand from the Supreme Court in Tee, we concluded that remand to the Referee for the submission of further evidence was appropriate. Betty S. Tee, 45 Van Natta 289 (1993). Inasmuch as the record before us in Tee had been developed prior to the Supreme Court's recent definition of the important statutory term ("gainful occupation"), we determined that the record regarding whether the part-time jobs in question (telemarketer and hotel/motel inspectress) was understandably inadequate. Considering such circumstances, we remanded for further evidence concerning whether the aforementioned jobs represented employments for "profitable remuneration."

Here, as in Tee, the salient issue is whether part-time work (advertising sales representative) constitutes a "gainful occupation." Again, as was the case in Tee, the present record was developed prior to the Supreme Court's pronouncement regarding the definition of that important statutory term. In light of these particular circumstances (where claimant's entitlement to PTD depends on whether part-time employment constitutes a "gainful occupation" under ORS 656.206(1)(a)), we find: (1) the record to be incompletely and insufficiently developed;[1] (2) evidence concerning this issue to have been

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[1] A vocational counselor submitted a labor market survey reporting concerning potential salaries and/or commissions as an advertising sales representative. (Ex. 32). Such information provides evidence regarding projected income for such employment. Nevertheless, the record is essentially devoid of evidence pertaining to the financial expenditures (if any) that claimant would realize in such a position. (For example, transportation costs, supplies expenses, etc.)

unobtainable with the exercise of due diligence at the time of hearing; and (3) a compelling reason to remand for the submission of additional evidence on this issue.

Accordingly, we remand this case to Referee Black with instructions to admit further evidence bearing on the issue of whether advertising sales representative jobs constitute employment for "profitable remuneration." The Referee shall conduct further proceedings to admit this evidence in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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March 25, 1993 Cite as 45 Van Natta 536 (1993)

In the Matter of the Compensation of
**JOSEPH E. KELLY, Claimant**
WCB Case Nos. 91-06705 & 91-05122
ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney
Roberts, et al., Claimant Attorneys

The SAIF Corporation requests reconsideration and abatement of our February 24, 1993 Order on Review which held it, rather than Kemper Insurance Company (Kemper), responsible for claimant's left elbow condition and right wrist de Quervain's tenosynovitis. Specifically, SAIF contends that responsibility should be initially assigned with Kemper, because claimant first sought treatment for these conditions during his employment with Kemper's insured. SAIF further argues that responsibility remains with Kemper.

In order to further consider SAIF's motion, we withdraw our February 24, 1993 order. Kemper and claimant are granted opportunities to respond. To be considered, responses must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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March 25, 1993 Cite as 45 Van Natta 536 (1993)

In the Matter of the Compensation of
**JON T. MARS, JR., Claimant**
WCB Case No. 92-01535
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of Referee Galton's order that affirmed an order of the Director of the Department of Insurance and Finance dismissing claimant's request that the Director review his likely eligibility for vocational assistance. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was time-barred by his "own motion" status from receiving vocational assistance benefits. We disagree.

Subsequent to the Referee's order, we held in David F. Meissner, 45 Van Natta 249 (1993), that the Director has jurisdiction to consider an "own motion" claimant's request for vocational assistance. That is, the expiration of aggravation rights alone does not disqualify a claimant from requiring vocational assistance. We concluded that claimants are not disqualified from vocational assistance merely because they are no longer eligible to receive permanent disability benefits. Meissner, supra.

A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available or suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment. ORS 656.340(6)(a).

Here, SAIF received a request for vocational assistance from Dr. Tarlow, claimant's attending orthopedist. See OAR 436-120-035(1)(a). In his letter, Dr. Tarlow stated:

> "[Claimant] is in a difficult situation with regard to employment. Prior to his injury he was a specialist machinist. However, because of the moderate osteoarthritis in his knee and the loss of his medial meniscus and the symptoms associated with this, he is unable to return to his preinjury work. * * * It would be reasonable to have [claimant] undergo vocational retraining so that he is out of a physical type of work and into one that does not require as much physical activity. Because of his arthritic knee, he will not be able to return to work in heavy labor, but he is too young to be disabled for life."

SAIF denied vocational assistance benefits on the sole basis that claimant's aggravation rights had expired. Subsequently, the Director dismissed claimant's request for vocational assistance on the same basis. Other than the expiration of his aggravation rights, claimant satisfies the eligibility requirements for vocational assistance under ORS 656.340(6).

Based on Meissner, surpa, we reverse the Referee and modify the Director's order. Claimant has satisfied the eligibility requirements for vocational assistance. See ORS 656.340(6)(a). Accordingly, SAIF is directed to provide claimant the same vocational assistance benefits he would receive if his aggravation rights had not expired.

Inasmuch as this order has resulted in increased compensation, claimant's attorney is awarded 25 percent of that increase, not to exceed $3,800, payable directly to the attorney from the insurer. ORS 656.386(2); OAR 438-15-055(1); Simpson v. Skyline Corporation, 108 Or App 721 (1991).

## ORDER

The Referee's order dated June 24, 1992 is reversed. The Director's order is modified to provide that claimant is entitled to receive the same vocational assistance services he would receive if his aggravation rights had not expired. Claimant's attorney is awarded a fee equal to 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable directly to the attorney from the insurer.

In the Matter of the Compensation of
**RONALD P. OLSON, Claimant**
Own Motion No. 92-0582M
OWN MOTION ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Williams, et al., Defense Attorneys

The claimant requests reconsideration of our January 26, 1993 Own Motion Order in the above-captioned case. In that order, we denied reopening claimant's claim for temporary disability benefits on the ground that he had not established that he was in the work force at the time of his compensable worsening. On reconsideration, claimant submits additional information in support of his argument that he was in the work force at the relevant time.

On February 25, 1993, we withdrew our order for reconsideration and granted the self-insured employer an opportunity to respond to claimant's motion. We have received the employer's response.

As a preliminary matter, our January 26, 1993 order found that claimant's condition worsened in May 1992 and that he did not prove he was in the work force at the time of that worsening. Claimant argues that his condition worsened in February 1992, rather than in May 1992, the date he underwent low back surgery. In support of his argument, claimant submits information from Dr. Markham, treating neurosurgeon. Specifically, according to this information, on February 2, 1992, claimant went to the Emergency Room for treatment of low back pain. Claimant was referred to Dr. Markham, who, on February 25, 1992, after examining the results of an MRI scan, recommended a lumbar laminectomy at L4-5. Dr. Markham opined that the need for the surgery was caused by the original July 1980 work injury. (Chart note from Dr. Markham dated February 25, 1992 and letter from Dr. Markham dated March 5, 1992). This surgery was authorized by the employer and performed on May 22, 1992. We find that this information establishes that claimant's compensable low back condition worsened in February 1992 and authorization for surgery was requested at that time.

However, in order to establish entitlement to temporary disability benefits, claimant must establish that he was in the work force at the time of his disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). Claimant has submitted a signed statement dated February 6, 1993 from Mr. Howell C. Birdwell stating that he hired claimant to do approximately three months reconstruction work at his home beginning in March 1992. Mr. Birdwell also stated that, before claimant started this project, claimant informed him that he would be unable to do the work due to his back injury.

Noting that Mr. Birdwell neither stated whether claimant previously worked for him nor the terms of employment, the employer argues that Mr. Birdwell's statement does not establish that claimant was in the work force. We disagree. Whether claimant previously worked for Mr. Birdwell does not bring into question Mr. Birdwell's statement that he hired claimant to begin a three month project in March 1992. In addition, although it is true that Mr. Birdwell's statement does not set out the terms of the employment, it does state that Mr. Birdwell hired claimant to do reconstruction work at Birdwell's home.

The employer also argues that a February 1992 letter and chart note from Dr. Markham, which indicated that claimant was not currently working and had not worked in many years, establishes that claimant was not in the work force. However, apparently Dr. Markham was not aware of the fact that Mr. Birdwell had hired claimant to perform reconstruction work. Given this fact, we do not find Dr. Markham's statements regarding claimant's employment status persuasive. Instead, we find that Mr. Birdwell's statement establishes that claimant was in the work force at the time his condition worsened in February 1992. In addition, claimant's statement to Mr. Birdwell regarding his inability to perform the scheduled work is supported by the fact that Dr. Markham had recommended low back surgery in February 1992.

In making this decision, we note that being in the work force is not a static condition. Therefore, although claimant may have had gaps in his employment history in the past, the evidence establishes that he was in the work force at the time his condition worsened.

Therefore, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

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 employer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

Accordingly, our January 26, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 26, 1993 order effective this date. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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March 26, 1993 Cite as 45 Van Natta 539 (1993)

In the Matter of the Compensation of
**TERESA A. FORBES, Claimant**
WCB Case No. 92-05725
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of Referee Quillinan's order which: (1) found that claimant's neck injury claim was prematurely closed; and (2) declined to rate the extent of claimant's unscheduled permanent disability. On review, the issues are premature closure and extent. We reverse the Referee's premature closure finding and affirm the Order on Reconsideration award of a total of 19 percent (60.8 degrees) unscheduled permanent disability.

## FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's neck injury claim had been prematurely closed by an August 12, 1991 Determination Order. The Referee reasoned that claimant's symptoms had not changed between June 1991 and March 1992, and that unprescribed physical therapy was available to claimant in June 1991. Citing Schuening v. J. R. Simplot, 84 Or App 622 (1987), the Referee relied on the post-closure opinion of the medical arbiter, Dr. Ayers, rather than claimant's treating physician, Dr. Brett, and concluded that claimant was not medically stationary. We disagree.

Medically stationary means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addressed the condition at the time of closure. Schuening, supra, 84 Or App at 625. It is claimant's burden to prove that her claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). Resolution of the medically stationary date is primarily a medical question resolved by competent medical evidence. Harmon v. SAIF, 54 Or 121 (1981). Further, we generally give greater weight to the opinion of the treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's treating physician, Dr. Brett, found claimant medically stationary on June 12, 1991. A Determination Order issued on August 12, 1991. On March 13, 1992, Dr. Brett again stated that claimant's condition was medically stationary. On March 23, 1992, Dr. Ayers, orthopedic surgeon, examined claimant and issued an arbiter's report. In that report, Dr. Ayers stated, "[a]t this point, I would think that the patient is probably not medically stationary, based on the idea that given a good rehabilitation program, I think she would gain significantly better range of motion." (Ex. 43-4).

Inasmuch as Dr. Ayers' report addressed claimant's condition at the time of his examination, rather than at the time of claim closure in August 1991, we conclude that his opinion concerning

claimant's medically stationary status is not persuasive. Further, Dr. Ayers' proposal of physical therapy is not inconsistent with Dr. Brett's finding claimant medically stationary as of June 12, 1991. 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. Alton H. Shotwell, 43 Van Natta 2421 (1991); Bobby G. Todd, 42 Van Natta 1648 (1990). Finally, because Dr. Brett was claimant's treating physician and observed him before and after closure, we rely on his opinion and conclude that claimant's claim was not prematurely closed. See Kienow's Food Stores v. Lyster, 79 Or App 416 (9186).

Because we have concluded that claimant's claim was not prematurely closed, and the record is sufficiently developed to consider extent of unscheduled permanent disability, we proceed with that determination. At hearing, the parties stipulated to all factors except adaptability. Thus, the only issue in dispute is whether claimant was released to regular work. In the event that the claim had been properly closed, the Referee offered the opinion that claimant was not entitled to a factor for adaptability because she was "released for regular work meaning her job at injury." (O&O at 5). We agree, but for the following reasons.

Shortly after her February 1988 compensable injury, claimant was released to regular work and returned to that work as a vehicle assembler. The strength category for that job was medium. (Tr. 5). Claimant worked at that job until the assembly plant closed in 1989. In November 1989, she began a new job working as a bookkeeper/data processor. (Tr. 21). The strength category for that job is light.

In November 1990, claimant's 1988 injury claim was reopened for surgery. On June 12, 1991, Dr. Brett released claimant "for all activities without restrictions . . . ." (Ex. 33).

Former OAR 436-35-310(2) states:

> "For workers who at the time of determination have a physician's release to regular work, or have either returned to or have the RFC for regular work or work requiring greater strength than work performed on the date of injury, the value for factor of adaptability is 0. (Emphasis added).

Former OAR 436-35-270(3)(c) defines regular work as "substantially the same job as held at the time of injury." Because claimant was released to work with no restrictions, we conclude that she had a physician's release to her regular work at the time of her injury, and/or that she had the RFC for that regular work. See former OAR 436-35-310(2). Accordingly, we conclude that her value for adaptability is 0.

Because the adaptability factor, 0, is a multiplier, claimant is entitled to no non-impairment values. Former OAR 436-35-280(6). Inasmuch as claimant's 19 percent impairment is undisputed, we conclude that claimant's unscheduled permanent disability under the standards is 19 percent (60.8 degrees). Former OAR 436-35-280(7). Consequently, we affirm the Order on Reconsideration which had awarded claimant a total award to date of 19 percent.

## ORDER

The Referee's order dated August 12, 1992 is reversed. The April 24, 1992 Order on Reconsideration is reinstated and affirmed. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
**KONNIE SPRUEILL, Claimant**
Own Motion No. 92-0549M
OWN MOTION ORDER ON RECONSIDERATION
Robert G. Dolton, Claimant Attorney

Claimant requests reconsideration of our January 26, 1993 Own Motion Order. In that order, we found that claimant failed to establish that she was in the work force at the time her condition worsened requiring surgery in August 1992. On that basis, we denied claimant's request for own motion relief. With her request for reconsideration, claimant submits two letters from Dr. Van Hal, her treating D.O., which she contends establish her inability to work or seek work from May 1989 through August 1992.

On February 24, 1993, we withdrew our order for reconsideration and granted the insurer an opportunity to respond. The insurer's response has been received.

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. In order to prevail, claimant must prove that she is willing to work and the either: (1) she is making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would be futile because of the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Wayerhaeuser Company, 229 Or 290 (1985).

Here, claimant's compensable condition worsened, requiring surgery in August 1992. Claimant contends that two letters from Dr. Van Hal establish that she was in the work force because, as a result of her injury, any efforts to obtain work would have been futile. We disagree.

Claimant's compensable injury is limited to her low back condition. In a letter dated May 21, 1991, Dr. Van Hal stated that claimant was not capable of working at a full-time manual labor job because of her temporomandibular joint syndrome (TMJ), her bulging L5-S1 disc, and her psychological condition. In a letter dated February 4, 1993, Dr. Van Hal stated:

> "As of August 1992, this patient was still incapable of working in the work force because of low back problems, TMJ problems, and headaches. She was unable to seek work of any kind at that time. The back pain was not allowing her to sit for long periods of time. The headaches that she was getting from her TMJ were to the extent that they were interfering with normal activities of normal living, even at home.
>
> "This patient was not capable of working from May 1989 through August 1992."

Although Dr. Van Hal's letters establish that claimant was unable to work during the relevant time period, they do not establish that this inability was due to her compensable low back injury. In fact, it appears that the headaches caused by the noncompensable TMJ condition were the most limiting in that they interfered with normal activities of daily living. In any event, the most that Dr. Van Hal's letters establish is that a combination of several problems, including the compensable low back injury, resulted in claimant's inability to work during the relevant time.

However, pursuant to Dawkins, supra, "[a] claimant who is not employed, is not willing to be employed, or, although willing to be employed, is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force." Dawkins, supra, (emphasis added). Dr. Van Hal's letters do not establish that the work-related injury is the cause of claimant's inability to work or seek work. In addition, those letters do not establish claimant's willingness to work. Dawkins, supra. Therefore, we continue to find that claimant was not in the fork force at the time of August 1992 worsening.

Accordingly, as supplemented herein, we adhere to and republish our January 26, 1993 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

In the Matter of the Compensation of
**KENNETH FELTON, Claimant**
Own Motion No. 92-0598M
OWN MOTION ORDER ON RECONSIDERATION
EBI Companies, Insurance Carrier

Claimant requested reconsideration of our February 5, 1993 Own Motion Order that denied the reopening of his claim for temporary total disability benefits. In order to consider claimant's request, we abated our prior order on March 2, 1993 and requested the insurer to respond to the following questions: (1) is the requested right knee surgery reasonable and necessary for the compensable injury; (2) has claimant sustained a worsening of his compensable injury; and (3) was claimant in the work force at the time of the current worsening.

The insurer concedes that claimant's condition has worsened and that the requested right knee surgery is reasonable and necessary for the compensation injury. However, 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. In order to prevail, claimant must prove that he is willing to work and that either: (1) he is making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would be futile because of the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Wayerhaeuser Company, 229 Or 290 (1985). Claimant has the burden of proof on this issue.

The insurer contends that claimant has removed himself from the work force due to a condition which he sustained while employed by a new employer in May 1990 and is currently being compensated through disability benefits for that worker's compensation claim. The insurer alleges that the May 1990 claim is insured by the SAIF Corporation and has a diagnosis of "nervous system mental stress subjected to job pressure."

Claimant contends that he has not removed himself from the work force but is unable to work due to disability from "(1) a post traumatic stress disorder, (2) anxiety, (3) depression and (4) stress." He also contends that he is "attempting some schooling and working on a complete life style change . . .. willing to work but must find an occupation that addresses my physical as well as medical limitations."

Neither claimant nor the insurer submit any evidence to support their contentions. In addition, there is nothing in this record that indicates that the psychological problems that claimant alleges make him unable to work are part of his compensable right knee claim with the insurer. As stated above, to prove his contention, claimant must establish that he is willing to work but reasonable work search efforts are made futile by his compensable injury, that is, his right knee injury. See Konnie Sprueill, 45 Van Natta 541 (1993). Thus, on this record, claimant has not established that he was in the work force at the time of his compensable worsening.

Accordingly, as supplemented herein, we adhere to and republish our February 5, 1993, 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
**BRIAN D. LINDSTROM, Claimant**
WCB Case No. 92-02762
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Podnar's order that: (1) declined to admit a video tape offered by the insurer for impeachment purposes; (2) set aside its denial of claimant's occupational disease claim for a left foot condition; (3) assessed a penalty for the untimely payment of interim compensation; and (4) assessed a penalty for the failure to timely provide claims information. Noting that the insurer has processed the claim in response to the Referee's order, claimant has also moved for dismissal of the insurer's appeal. On review, the issues are the motion to dismiss, the Referee's evidentiary ruling, compensability, and penalties. We deny the motion to dismiss, reverse in part and affirm in part.

Motion to Dismiss

After the insurer filed its Request for Board Review, it issued a Notice of Closure (NOC) to claimant. In his Motion to Dismiss, claimant contends that that action mooted the insurer's appeal, because claim processing is inconsistent with the denial of compensability. In Loren Callihan, 41 Van Natta 1449 (1989), we concluded that an insurer's compliance with a referee's order pending appeal does not moot its appeal. We reasoned that, "[t]he fact that subsequent actions have been lawfully 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. Rather, that question remains subject to our jurisdiction. See ORS 656.289(3); 656.295(6)." 41 Van Natta at 1450.

In his order, the referee remanded the claim to the insurer for processing consistent with the Workers' Compensation Law. The insurer complied with that directive by processing the claim to closure. See ORS 656.268(2). Consequently, the insurer's appeal is not moot. Claimant's motion is, therefore, denied and we proceed to the merits of the insurer's appeal.

## FINDINGS OF FACT

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

Between March 9 and 13, 1992, claimant was capable of bearing weight on, and flexing, his left foot with no obvious difficulty or discomfort.

The insurer did not stipulate to the imposition of a penalty for its failure to timely pay interim compensation.

## CONCLUSIONS OF LAW AND OPINION

Admissibility of the Surveillance Video

At the hearing, the insurer sought to impeach claimant by submitting approximately 15 hours of surveillance videos taken between March 9 and March 13, 1992. In those videos, claimant is seen engaging in numerous activities involving the use of his left foot, including walking, climbing a ladder, tearing off roofing materials, using his left foot as a brace for a pry bar, carrying bundles of roofing and construction materials and pushing piles of shingles off a roof. Most of those activities involved extensive weight bearing on his left foot, and claimant wore light-weight athletic shoes. Nevertheless, he exhibited no difficulty or pain in performing any of those tasks.

The Referee refused to admit the videos for impeachment purposes, concluding that the tapes were not inconsistent with claimant's testimony. In short, the Referee excluded the tapes, because he did not think that they proved what the insurer claimed.

ORS 656.283(7) provides that the "referee is not bound by common law or statutory rules of evidence * * * and may conduct the hearing in any manner that will achieve substantial justice." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Moreover, OAR 438-07-017 provides that evidence "reasonably believed relevant and material only for purposes of impeachment of a witness * * * may be offered and admitted solely for impeachment." (Emphasis supplied.) Because the language of that rule is permissive, the Referee has discretion as to whether to admit impeachment evidence offered under that rule. See e.g., Dean L. Watkins, 43 Van Natta 527, 529 (1991). Consequently, we review for an abuse of discretion.

Whether the tapes prove what the insurer contends is a question concerning the weight of the evidence, not its admissibility. Admissibility, in this context, is contingent upon relevance. See OAR 438-07-017. Evidence is relevant if it has any tendency to make the existence of any fact that is of consequence to the determination more or less probable. Because the tapes have some bearing on claimant's credibility, which is an issue in this case, they are relevant and admissible. See Frank C. Jones, 41 Van Natta 138, 140 (1989). Therefore, we conclude that it was an abuse of discretion for the Referee to exclude the video tapes. Because the disputed evidence is already in the record, we admit it into evidence and proceed with our review. Warren G. Kucera, 43 Van Natta 2782, 2783 (1991).

Compensability

The Referee concluded that claimant's left foot condition was a compensable occupational disease, based on the physicians' reports. He reasoned that, because there is no contrary medical opinion, those reports provide the objective findings necessary to establish the compensability of the claim.

To establish compensability, claimant must prove that his employment conditions were the major contributing cause of his left foot condition. ORS 656.802(1)(c). In addition, he must establish the existence of the disease by medical evidence supported by objective findings. ORS 656.802(2). The insurer contends that claimant failed to prove the existence of the disease, because the physicians' opinions were not based on a credible medical history. We agree.

The diagnosis of claimant's foot condition was based on his relation of his medical history. An objective finding of the existence of a disease may be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471, 475 (1992). Nevertheless, it is also true that a physician's opinion is entitled to little, if any, weight if it is based on an inaccurate history. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Consequently, when an objective finding is based on a claimant's relation of medical history, the claimant's credibility is of critical importance.

We are as capable as the Referee at assessing credibility when we do so based on the substance of the evidence, instead of the witnesses' demeanor. Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984). When claimant was examined by his treating physician, Dr. Hoppert, M.D., on January 15 and 21, 1992, he complained of pain in the distal aspect of the first metatarsal head and the first webbed space as well as tenderness at the metatarsophalangeal joint. At the hearing, claimant testified that when he again saw Dr. Hoppert on February 26, 1992, his symptoms had not changed from his earlier reports. When asked to describe how his foot felt, claimant testified:

> "Claimant: Yeah. It was like -- it was -- like -- well, I've never broke my foot or anything before, but it felt like way more than a sprain. When I walked, I'd bear all the weight basically on my heel as much as possible. It was almost like I should probably have had crutches. When I would try to -- if I would try to roll my foot in a normal walking fashion, there would just be pain, pain in the -- above my -- you know, arch forward." (Tr. 17).

The insurer then asked claimant whether he experienced the same kind of pain on or around March 10, 1992:

> "Insurer: And my next question to you was were you still having pain in the left foot despite the fact that you didn't go see Dr. Woll?

"Claimant: Yes, plenty.

"Insurer: What do you mean by plenty?

"Claimant: Not -- not nearly as much as the day -- the night -- the day that it occurred, or the 19th. It seemed to be, you know, a good percentage better, but still there's -- there's still obviously something wrong with it.

"* * * * *

"Insurer: Were you still hobbling at that time? Were you still having that type of pain?

"Claimant: Walking on my -- walking on my heel, eating a lot of Motrin and icing it in the evening and in the morning, a couple of times a day.

"Insurer: Dr. Hoppert the last time he had seen you on February 26 felt you were not medically stationary, which means that you weren't -- hadn't reached total improvement and that he restricted you to sedentary employment. Do you feel that your condition was -- on March 10, 1992, was basically the same as it was on February 26, 1992, when Dr. Hoppert had last seen you?

"Claimant: Oh, yes.

"Insurer: So you would still be unable to go back to do your regular work because of the pain?

"Claimant: Yeah." (Tr. 19-20).

As the surveillance tapes show, claimant was not hobbling or walking on his heel on March 9, 1992. That indicates that claimant's description of his pain on or around that date was inaccurate. See Andrew L. Martin, 35 Van Natta 1389, 1391 (1983). Because claimant testified that his pain on or around March 9, 1992, was similar to the pain he related to his physicians, we can infer that his earlier reports were also inaccurate. Because claimant provided an inaccurate medical history, the physicians' opinions concerning the existence of a disease are entitled to little weight. Consequently, claimant failed to prove the existence of a disease with objective findings, and we reinstate the insurer's denial.

Penalties

The insurer contends that the Referee erred in assessing a penalty for its late payment of interim compensation. At the hearing, the insurer stipulated that it paid interim compensation late, and the Referee imposed a penalty/attorney fee for that violation. Nevertheless, the insurer argues that it should not have to pay that penalty, because the claim was not compensable. We disagree.

The penalty/attorney fee that the Referee awarded was derivative of the insurer's failure to comply with its obligation to timely pay interim compensation. ORS 656.262(4)(a). Because that obligation exists regardless of the compensability of the underlying claim, the insurer cannot now avoid the derivative consequences of its failure to comply with that obligation simply because claimant failed to prove compensability.

The insurer also contends that the Referee erred in assessing a penalty for failing to timely provide claims information to claimant. The Referee construed the insurer's action as an unreasonable resistance to the payment of compensation, and assessed a penalty of 25 percent of any increased compensation made payable by its order.

Because we have found the claim noncompensable, the insurer's failure to provide the requested claims information did not constitute a delay or refusal to pay compensation. ORS 656.262(10); Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991); Debra L. Beeson, 43 Van Natta 2752 (1991). Inasmuch as penalties are not compensation for purposes of ORS 656.382(2), claimant's attorney is not entitled to an attorney fee for services provided on Board review concerning the "interim compensation" penalty issue.

ORDER

The Referee's order dated September 1, 1992 is affirmed in part and reversed in part. Those portions of the order concerning the denial of claimant's left foot disease claim, the penalty for failing to timely provide claims information and the carrier-paid attorney fee are reversed. The insurer's denial is reinstated and upheld. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**BRIAN W. ANDREWS, Claimant**
WCB Case No. 91-18171
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Lipton.

Claimant, pro se, requests review of Referee Barber's order that upheld the SAIF Corporation's denial under ORS 656.262(6) of claimant's left ankle injury claim. No briefs were submitted by the parties. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 40 years old at hearing, sprained his left ankle on August 24, 1991, during a company picnic. (Exs. 1 and 4).

SAIF accepted the claim as a compensable nondisabling injury on November 19, 1991. (Ex. 7). On November 20, 1991, SAIF issued a denial, on the basis that claimant's injury did not arise from his employment. (Ex. 8).

The company picnic is held annually. The employer provided meat and soda pop. Attendees, which included management, employees and their families, played baseball and volleyball and ate lunch. The employees were not paid to attend the picnic and it did not take place on the employer's premises.

FINDINGS OF ULTIMATE FACT

The picnic was not primarily for the benefit of the workers.

CONCLUSIONS OF LAW AND OPINION

If an insurer accepts a claim in good faith, but later obtains evidence that the claim is not compensable, it may revoke the claim acceptance and issue a formal notice of claim denial. If the worker requests a hearing on the denial, the insurer must prove by clear and convincing evidence that the claim is not compensable. ORS 656.262(6). To be "clear and convincing" all the evidence, taken together, must be highly probable, free from confusion, fully intelligible and distinct. Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987); Connie Von Eynern, 43 Van Natta 2657 (1991).

Here, the SAIF Corporation accepted the claim as compensable on November 19, 1991, after being fully informed by claimant of the circumstances under which the injury was sustained. We, accordingly, find that the acceptance was issued in good faith. On November 20, 1991, SAIF issued a back-up denial on which claimant requested a hearing. At hearing, SAIF contended that claimant's injury was incurred while engaging in a recreational or social activity primarily for the worker's personal pleasure. ORS 656.005(7)(b)(B). The insurer bears the burden of proving by clear and convincing evidence that the claim is not compensable by showing that the picnic was primarily for the worker's personal pleasure. ORS 656.262(6).

The Referee concluded that claimant was not truthful, based on inconsistent statements. We are equally capable of assessing credibility based on an objective evaluation of claimant's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our review of claimant's testimony, we find no contradiction sufficient to justify the Referee's conclusion that claimant was not truthful.

The sole evidence offered by SAIF on the issue of whether the picnic was primarily for the workers' pleasure was the testimony of Morgan Conner, one of five managers in a total work force of 22 employees as of the date of injury. Mr. Conner thought that Hal, the parts driver, organized the picnic, but he admitted that he really did not know, since he was not on the organization committee. Mr. Connor knew that management contributed meat and soda pop. He also heard Mark Denny, the owner, state that he absolutely would not provide alcohol for the picnic. Mr. Connor further testified that attendance by employees was not mandatory; employees signed up to bring food; both employees and management donated money; the employees organized the baseball and volleyball games; the picnic did not increase their petroleum equipment business; employees were not paid to attend; it was not held on the employer's premises; and, as far as he was aware, the management did not direct the way in which the picnic was to take place. Connor did not know who reserved the picnic area or who bought the kegs of beer.

On the significant issue of whether the picnic was primarily for the workers' pleasure, Mr. Connor answered that, in his opinion, the picnic was held for the benefit of the employees.

In contrast, claimant, who also was not on the organizing committee, thought Mark Denny, the owner, must have put on the picnic because, to the best of his knowledge, the employees did not organize the picnic. He based his assumption on the fact that he is an employee and no one asked him to organize it, and as far as he knows, none of the other employees he worked with organized it. He said that Hal, the owner's father-in-law, was not the main organizer. Also, he testified that Bob Daily, a manager, ordered the kegs of beer, although he does not know who paid for the beer. He also believed that Mark Denny paid for the prizes.

Claimant thought the benefit to the employer and employees was equal. He did not believe that the picnic was primarily for the workers' benefit. (Tr. 42). Instead, he believed that the benefit to the employer was to increase morale by getting management, the owner and families together. (Tr. 43).

The record indicates that neither Mr. Connor nor claimant had much personal knowledge about the purpose and organization of the picnic. However, Mr. Connor's testimony on the question of whether the recreational or social activity was primarily for claimant's personal pleasure was directly challenged by claimant. Insofar as the testimony presented supports either the testimony of Mr. Connor or claimant, it supports each equally. The evidence is, therefore, in equipoise.

We, accordingly, conclude that SAIF has failed to prove by clear and convincing evidence that the picnic was primarily for the benefit of the workers. Consequently, we set aside its November 20, 1991 denial.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). Although he appeared pro se on review, claimant was represented by counsel at hearing. Accordingly, his attorney is entitled to a fee for his services at hearing. 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 $1,500, 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 hearing record), the complexity of the issue, and the value of the interest involved.

## ORDER

The Referee's order dated March 19, 1992 is reversed. The SAIF Corporation's denial dated November 20, 1991 is set aside and claimant's claim is remanded to the SAIF Corporation for processing according to law. Claimant's attorney is awarded $1,500 for services at hearing, to be paid by SAIF.

In the Matter of the Compensation of
**NANCY G. BROWN, Claimant**
WCB Case No. 92-06488
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Tenenbaum's order that: (1) found claimant was entitled to a resumption of temporary disability benefits; and (2) assessed a penalty for the employer's allegedly unreasonable termination of temporary disability. In her brief, claimant asks that the Referee's order be clarified with regard to the award of an approved attorney fee. On review, the issues are temporary disability benefits, penalties and attorney fees. We affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the findings of fact as set forth in the Referee's order.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Benefits

We adopt the Referee's conclusions and reasoning with the following supplementation.

A carrier may procedurally terminate temporary disability benefits without the claimant being medically stationary if one of the conditions set forth in ORS 656.268 is met. Soledad Flores, 43 Van Natta 2504 (1991). ORS 656.268(3) provides:

> "Temporary 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."

None of the conditions set forth in ORS 656.268(3) have been met. Consequently, the employer could not terminate temporary disability benefits pursuant to that provision.

The employer argues that it is permitted to terminate temporary disability benefits pursuant to ORS 656.005(7)(a)(B). That is, the issuance of its denial pursuant to that provision allowed it to terminate claimant's temporary disability benefits. The accepted condition is a low back strain. The employer's denial purports to deny claimant's current low back condition on the basis that the current low back condition is not related to the injury, but rather to preexisting problems, including degenerative disc disease. We conclude that such circumstances do not entitle the employer to terminate claimant's temporary disability.

Under ORS 656.007(a)(B), a worker is not entitled to resultant disability and medical treatment where a preexisting condition combines with a compensable injury unless the worker establishes that the compensable injury is and remains the major contributing case of the disability and need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). However, as noted by the Referee, ORS 656.007(a)(B) is a definitional statute. It is a basis for determining a worker's substantive rights to disability and medical treatment. It is not a claims processing statute like ORS 656.268(3).

Notwithstanding the denial, the employer is still responsible for an accepted claim from which temporary disability benefits were being paid. While a preclosure denial issued pursuant to ORS 656.005(7)(a)(B) is permissible, see Daniel R. Bakke, 44 Van Natta 831 (1992), it is not a basis for terminating temporary disability benefits on an open claim. ORS 656.268(3) provides grounds for procedurally terminating temporary disability benefits in such a situation and, as noted above, none of the criteria set forth in ORS 656.268(3) have been met. In addition, there is no Department order authorizing the termination or suspension of temporary disability benefits pursuant to OAR 436-60-085, 436-60-095 or 436-60-105.

Finally, there is no contention that the employer failed to receive medical verification of an inability to work as required by ORS 656.262(4)(b). Pursuant to ORS 656.262(4)(b), a carrier may "suspend" temporary disability benefits if the attending physician is unable to verify a worker's inability to work due to the compensable injury until such time as verification is obtained. Sandoval v. Crystal Pine, 118 Or App 640 (1993). However the suspension of benefits pursuant to ORS 656.262(4) does not terminate a claimant's entitlement to temporary disability benefits under ORS 656.268. Id. The only means for a carrier to unilaterally "terminate" temporary disability benefits is pursuant to ORS 656.268(3) and the entitlement to those benefits continues until the requirements of that statute are met. Id.; Northrup King & Co. v. Fisher, 91 Or App 602, rev den 307 Or 77 (1988).

Accordingly, we agree with the Referee that the employer was not entitled to terminate claimant's temporary disability benefits.

Penalties

We adopt the conclusions and reasoning concerning the penalty issue as set forth in the Referee's order.

Attorney Fees

In her order, the Referee awarded claimant's counsel 25 percent of the increased temporary disability created by the order. We modify the Referee's order to award claimant's counsel 25 percent of the increased temporary disability benefits created by the Referee's order, not to exceed $1,050.

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 temporary disability issue is $1,000, 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. 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 June 25, 1992 is modified in part and affirmed in part. The Referee's order is modified to award claimant's counsel 25 percent of the increased compensation created by the Referee's order, not to exceed $1,050. The remainder of the order is affirmed. For services on review concerning the temporary disability issue, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
**DANNY R. MARSHALL, Claimant**
WCB Case No. 91-16280
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Neal's order that set aside its denial of claimant's head and neck injury claim. On review, the issue is whether claimant's injury arose out of and in the course of employment. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The employer was unaware of employees walking through the kitchen to get to his office so he had no reason to discourage it. (Tr. 68).

## CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial. The Referee reasoned that: (1) claimant was on the employer's premises for a business purpose, not on a personal mission; (2) the injury occurred in an area where claimant normally worked; and (3) the employer acquiesced in claimant's presence in the kitchen because he had not stopped off-duty employees from being in the back rooms of the store. We disagree.

In order to prove the compensability of his claim, claimant must establish that his injury arose out of and in the course of his employment. ORS 656.005(7)(a). He may do so by proving that his injury was "sufficiently" work-related. Rogers v. SAIF, 289 Or 633, 642 (1985).

In Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985), the court discussed seven factors for determining whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and 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; (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 or her own. Whether an injury is work-related is a matter to be decided on a case-by-case basis; not all of the seven factors need be satisfied, and no single factor is dispositive. Preston v. SAIF, 88 Or App 327, 331 (1987); Haugen v. SAIF, 37 Or App 601, 604 (1978).

Claimant worked as a baker in a convenience store/deli. On October 3, 1991, claimant was not scheduled to work, although he was scheduled to work the next day. The afternoon of October 3, 1991, he went to the store to reschedule his work hours so that he could be with his children during their scheduled visitation which began on the night of October 11, 1991. Mr. and Ms. Nelson owned the store, and Mr. Nelson did the work scheduling. Mr. Nelson was not at the store when claimant arrived and claimant waited for him. Later, rather than going through the public area of the store to get to Mr. Nelson's office, claimant went through the kitchen where he slipped, fell, and hit his head and neck.

### Benefit to the Employer

The Referee found that claimant's activity of changing his work schedule at least indirectly benefited the employer by keeping his employee happy so that he would continue to work. Although we agree that this activity provided some benefit to the employer, the benefit was very slight. See Sheri V. Hiltner, 42 Van Natta 1039, 1040-41 (1990). The primary benefit was to claimant in that he was accommodating his personal responsibilities.

### Activity Contemplated by the Parties

Requests for shift changes were contemplated by the employer, who had complied with such requests in the past. However, the relevant question is whether the parties contemplated that claimant would travel through the employer's kitchen while he was off duty to make a shift change request.

The employer had a policy against off-duty employees loitering in or around the store. (Ex. 2-1). Also, no off-duty employees were allowed in the back room. (Ex. 2-2). These policies were stated in the employee handbook, a copy of which was kept on the break table. (Ex. 2, Tr. 56). Ms. Nelson testified that the policy was to give each new employee a copy of the handbook, although she could not recall whether she had given a copy to claimant. (Tr. 76, 77). She also testified that she did not verbally go through the general rules, but she urged the employees to read the handbook. (Tr. 77). Claimant testified that he never received a copy of the handbook while working for the employer. (Tr. 8-9).

On this record, we do not find that the parties contemplated that claimant would go into the employer's back rooms on his day off.

Ordinary Risk Incidental to Employment

Claimant argues that, because he worked in the kitchen as a baker, his slip and fall in the kitchen was an ordinary risk incidental to his employment. We disagree. Claimant overlooks a key factor -- he was on his day off when he fell in the kitchen. Slipping and falling in the employer's kitchen while on his day off cannot be said to be an ordinary risk of, and incidental to, claimant's employment as a baker.

Payment for the Activity

Claimant was not paid for his day off.

Activity on the Employer's Premises

The activity occurred on the employer's premises.

Employer Direction or Acquiescence

Claimant's employer did not direct him to come in on his day off and travel through the kitchen, rather than the public area of the store, to request a change in the work schedule. The question is whether the employer acquiesced in claimant going into the kitchen when he was off-duty.

Claimant testified that he had gone into the back rooms before when he was off duty and was never reprimanded. (Tr. 10). He testified that he had seen other off-duty employees in the back rooms and had never heard any of them be asked to leave. (Tr. 11).

The question is whether the employer was aware of these instances, or whether it would have allowed them to go unpunished if it were aware of them. Robin A. Arnold, 42 Van Natta 117 (1990). Mr. Nelson testified that he did not recall ever talking to claimant when claimant was off duty. (Tr. 57-58). He also testified that he had no reason to discourage anybody from going through the kitchen to his office because he had never seen anyone do that. (Tr. 68). Finally, he testified that he "may have told people from time to time to leave the kitchen if they weren't working. . . ." (Tr. 68).

As previously noted, Mr. Nelson testified that he did not recall talking to claimant when claimant was off duty. However, from the above quoted phrase, it appears that the employer was aware that off-duty employees were in the kitchen at times. Also, although apparently aware there were violations of the "no loitering" rule, Mr. Nelson did not enforce the rule, as evidenced by his statement that he "may have" told such employees to leave the kitchen. Because the employer did not enforce the "no loitering" rule, we find that he acquiesced in off-duty employees, including claimant, sometimes being in the kitchen.

Personal Mission

Claimant was on a personal mission of his own when he came in on his day off to arrange for time off to visit with his children. Claimant was scheduled to work the next day. There was no business reason that claimant could not have waited until the next day to request the change in the work schedule.

Conclusion

In combination, the factors preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Claimant was not engaged in an activity contemplated by the employer, was not engaged in an activity incidental to work, was not being paid, and was on a personal mission. While the activity was on the employer's premises, was acquiesced in by the employer, and was of slight benefit to the employer, these considerations are insufficient to establish the work connectedness of claimant's injury. See Douglas S. Methvin, 42 Van Natta 1291 (1990) (insufficient work connection where, after his regular hours, the claimant was looking for his wallet on the employer's property with the employer's permission).

ORDER

The Referee's order dated February 12, 1992 is reversed. SAIF's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

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March 29, 1993 Cite as 45 Van Natta 552 (1993)

In the Matter of the Compensation of
**CAROLYN R. PALMER, Claimant**
WCB Case No. C3-00668
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Andrew H. Josephson, Claimant Attorney
VavRosky, et al., Defense Attorney

On March 15, 1993, 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 dispose of any or all matters regarding a claim, except for medical services, subject to the terms and conditions prescribed by the Director of the Department of Insurance and Finance. The Director's rules define a "claim disposition agreement" as a written agreement which releases rights and obligations under ORS Chapter 656, except for medical services, in an accepted claim. OAR 436-60-005(9); see also OAR 438-09-001(1).

Here, the proposed disposition provides that the consideration for this agreement is based in part on medical bills that claimant has already paid. Apparently, at least some of the medical expenses are attributable to claimant's accepted low back condition. Consequently, by agreeing to pay those bills from settlement proceeds, by agreeing not to seek reimbursement claimant is effectively relinquishing a claim for medical benefits. That is an impermissible limitation on claimant's right to medical benefits for her compensable injury. See Marilyn London, 43 Van Natta 1689 (1991). Furthermore, the offensive portion of the disposition agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration. Accordingly, we find the agreement is unreasonable as a matter of law. See Louis R. Anaya, 42 Van Natta 1843, 1844 (1990) We therefore decline to approve the agreement. See ORS 656.236(1)(a).

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JUANA PIPER, Claimant**
Own Motion No. 92-0421M
OWN MOTION ORDER ON RECONSIDERATION
Scott McNutt, Claimant Attorney

Claimant requests reconsideration of our January 29, 1993 Own Motion Order. In that order, we determined that claimant was not in the work force at the time of her worsening. On that basis, we denied claimant's request for temporary disability benefits. With her request for reconsideration, claimant submits an affidavit stating that she was in the job market and looking for work during the period in question.

On February 26, 1993, we withdrew our January 29, 1993 order for reconsideration and granted the insurer an opportunity to respond to claimant's motion. The insurer's response has been received.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and making reasonable efforts to find work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof on this issue.

Claimant has submitted copies of her W-2 forms for 1990 and 1991 which establish that she was in the work force during those years. However, claimant must establish that she was in the work force at the time of her compensable worsening. On November 23, 1992, Dr. Matteri, treating orthopedist, recommended that claimant undergo surgery on her low back. The insurer authorized this surgery.

On December 17, 1992, claimant underwent an independent medical examination (IME) during which she reported that she last worked in February 1992 for about a month. By affidavit submitted with her request for reconsideration, claimant stated that she was in the job market from January 1992 through June 25, 1992 at which time she was unable to work due to her low back condition. She stated that her "job search consisted of looking at the want ads and newspapers where I considered jobs in the restaurant, nursing care and pizza parlor field." She also listed a specific interview on April 27, 1992 with a follow up on May 1, 1992 at Life Care Center in Cottage Grove for a CNA job.

The claims adjuster responded that the Life Care Center does not have a facility in Cottage Grove. Furthermore, the claims adjuster stated that Life Care Center has two locations in Oregon, one in Coos Bay where claimant was originally injured, and one in Eugene. The claims adjuster stated that she called the facility in Eugene and was told there was no record of an interview with claimant.

Subsequently, we received another affidavit from claimant stating that she mistakenly indicated the name of the care center at which she interviewed for a CNA job as "Life Care Center." She stated that she actually interviewed with a person named Dory at the "Coast Fork Nursing Center" in Cottage Grove.

In effect, claimant is arguing that she was willing to work and making reasonable efforts to find work until June 25, 1992 when her condition worsened making such efforts futile. However, other than her own statement, there is no evidence that claimant's condition worsened to the point that a reasonable job search would have been futile. The record contains no release from work or statement from Dr. Matteri regarding claimant's inability to work or seek work during the period in question.

In addition, assuming that claimant was in the work force in February 1992, we do not consider one job application and interview in a period of more than eight months (from March 1992 to November 23, 1992) to be a reasonable job search. Also, looking at want ads, without more, does not demonstrate a reasonable job search. Therefore, on this record, we continue to find that claimant has not established that she was in the work force at the time of her disability.

Accordingly, we withdraw our January 29, 1993 order. On reconsideration, as supplemented herein, we adhere to our January 29, 1993 order in its entirety. The parties rights to reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICHARD R. RUSSELL, Claimant**
Own Motion No. 92-0544M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
EBI Companies, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on October 22, 1985. The insurer denied the compensability of claimant's current condition and claimant has filed a request for hearing on that denial with the Hearings Division, WCB Case No. 93-01580.

As litigation is pending regarding the compensability of claimant's current need for medical treatment, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

The hearing is presently set before Referee !!1!!Podnar on May 6, 1993. At that hearing, if the current condition is found to be compensable, the Referee shall take evidence on the issue of whether claimant was in the work force at the time his condition worsened. A claimant is in the work force at the time of disability if he is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where he looked for work, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of his compensable condition for the period in question. At the conclusion of the hearing, the Referee shall forward to the Board a recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No. 93-01580.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**KIMBERLY M. SAYLOR, Claimant**
WCB Case No. 91-14284
ORDER ON RECONSIDERATION
Francesconi & Busch, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

On March 11, 1993, we withdrew our February 25, 1993 order which had affirmed a Referee's order that had set aside the SAIF Corporation's lumbosacral strain injury claim. We took this action to consider SAIF's contention that the compensability issue had been resolved pursuant to the parties' December 1992 referee-approved Disputed Claim Settlement (DCS). In response to SAIF's contention, claimant confirms that it was the parties' intention that "Board review be dismissed and [SAIF's] partial denial remain in full force & effect."

A review of the DCS establishes that it is designed to resolve all issues raised or raisable in this matter, in lieu of the Referee's order, as well as those in WCB Case No. 92-10934, a case which was pending before the Hearings Division. As previously noted, that portion of the agreement which pertains to the Hearings Division has already received Referee approval.

Pursuant to the settlement, claimant agrees that SAIF's denial, as supplemented by the agreement, "shall remain in full force and effect." The parties further agree that this matter shall be dismissed with prejudice. By this order, we approve those portions of the agreement which pertain to this matter, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RANDY L. SCOTT, Claimant**
WCB Case No. 92-04668
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of Referee Nichols' order that affirmed an Order on Reconsideration which awarded claimant 5 percent (7.5 degrees) scheduled permanent partial disability for loss of use or function of claimant's right knee. In its brief, the SAIF Corporation objects to the inclusion in claimant's brief of material excerpted from a medical treatise. On review, the issues are SAIF's objection to portions of claimant's brief and the extent of claimant's scheduled permanent disability.

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

Both at hearing and on review, claimant's sole argument concerning the extent of his permanent disability is that he was entitled to an impairment value for instability of his knee pursuant to OAR 436-35-230(3). In support of such an award, claimant notes the closing examination report by Dr. Lawton, his attending physician, who found "only slightly positive Lachman's test." (Ex. 10). In addition, he relies on the report of Dr. Becker, orthopedic surgeon, who performed a medical arbiter examination and reported "a very slight positive anterior drawer sign with a very slight positive Lachman maneuver * * *." (Ex. 14A).

The excerpted material which claimant has included in his appellant's brief includes a schematic drawing of the human knee from a medical treatise as well as textbook descriptions of Lachman's test and the anterior drawer sign. SAIF objects on the basis that this material was not admitted into evidence at hearing. In response, claimant requests that the Board take notice of this material, arguing that the proferred material is general in nature and that it does not constitute "adjudicative facts." Claimant notes that such materials are appropriate in his brief because "[i]t is always difficult to anticipate the Board's fluency in terms of medical science * * *."

We need not decide whether the material does, or does not, go to the proof of "adjudicative facts." Even if we were to consider the proferred material, we would still conclude that claimant has failed to establish entitlement to an impairment value for instability. In this regard, OAR 436-35-230(3) requires that an injured worker experience at least a 1 mm joint displacement in order to be entitled to such an award. Here, neither Dr. Lawton's report of "only slightly positive Lachman's test" nor Dr. Becker's report of "a very slight positive anterior drawer sign with a very slight positive Lachman maneuver" establish that claimant has a joint displacement of at least 1 mm. The material included in claimant's brief does not prove otherwise. Accordingly, claimant has failed to establish entitlement to an increased permanent disability award.

ORDER

The Referee's order dated July 10, 1992 is affirmed.

In the Matter of the Compensation of
**GREGORY A. WEIGEL, Claimant**
WCB Case No. 91-09058
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of those portions of Referee Myers' order that: (1) dismissed claimant's request for hearing; (2) set aside an Order on Reconsideration because it was invalidly issued; and (3) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). The insurer cross-requests review of that portion of the Referee's order which found that claimant had requested that a medical arbiter be appointed. On review, the issue is validity of the WCD's Order on Reconsideration. We affirm.

## FINDINGS OF FACT

On August 24, 1990, claimant sustained a compensable injury to his low back. The claim was closed by a February 19, 1991 Determination Order that did not award any permanent disability. The evaluator's worksheet attached to the Determination Order indicates that the evaluator relied on Dr. Quijano to find that claimant had no unscheduled permanent disability.

On May 14, 1991, claimant requested reconsideration of the Determination Order. His request for reconsideration was made on a form provided by the Department of Insurance and Finance. He checked "yes" next to the premature closure issue and indicated that he was relying on the "3-1-91 chartnote Dr. Gallagher." He checked "no" next to the impairment finding by the attending physician, but indicated that "Dr. Gallagher is tx dr." Finally, he also checked "yes" next to the rating of disability by Evaluation sub-issue and indicated that he was relying on "Lift & Chronic/Repetitive Gallagher 3-1-91 & Quijano 4-11-91."

On July 8, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all aspects. The order acknowledged claimant's reliance on Dr. Gallagher's March 1, 1991 chartnote, but indicated that the information referred to claimant's condition subsequent to the date of closure and therefore was not considered. The order then relied on Dr. Quijano to affirm the Determination Order. The claim was not referred to a medical arbiter prior to issuance of the Order on Reconsideration.

Thereafter, claimant requested a hearing concerning the Order on Reconsideration. At hearing, claimant contended that the Order on Reconsideration was invalid on the basis that the Director failed to appoint a medical arbiter and consider a medical arbiter's findings prior to the issuance of the reconsideration order.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and reasoning with the following supplementation.

Whether a party objects to the attending physician's impairment findings, so that appointment of a medical arbiter is required, is a question of fact. Dale A. Pritchett, 44 Van Natta 2134 (1992).

Here, claimant requested reconsideration by checking a box on the WCD form which provided that reconsideration was requested because claimant disagreed with premature closure and the rating of disability by the Evaluation Division. Additionally, although claimant specifically indicated that he did not disagree with the impairment findings of his attending physician at the time of claim closure, he did indicate that Dr. Gallagher, not Dr. Quijano, was the treating physician.

Under these circumstances, we agree with the Referee that claimant's reference to Dr. Gallagher indicated that he disagreed with the impairment findings of Dr. Quijano, who was the attending physician at the time of claim closure. Finally, claimant did not specifically waive his right to a medical arbiter. See Brenton R. Kusch, 44 Van Natta 2222 (1992). Accordingly, we agree with the Referee that the Order on Reconsideration was invalid. See Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992).

## ORDER

The Referee's order dated October 9, 1991 is affirmed.

In the Matter of the Compensation of
**GEORGE GODDARD, Deceased, Claimant**
WCB Case No. 91-04998
ORDER ON RECONSIDERATION
Royce, Swanson & Thomas, Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys

Claimant has requested reconsideration of our February 2, 1993 Order on Review. In that order, we agreed with the Referee that the insurer's delay in accepting or denying the claim was unreasonable. However, we declined to assess a penalty on medical bills which were unpaid on the date of the insurer's pre-hearing acceptance of the claim, but which had been paid by the date of hearing. Instead, we awarded an attorney fee pursuant to ORS 656.382(1).

On March 2, 1993, we abated our order to allow the parties an opportunity to discuss the holdings of several Board and court decisions. After consideration of the parties' responses, we issue the following order.

The Referee originally found the insurer's denial and its delay in paying compensation to be unreasonable. However, the Referee concluded that a penalty could not be assessed on medical bills pending acceptance or denial of the claim. On reconsideration, the Referee relied on our decision in Kim S. Jeffries, 44 Van Natta 824 (1992), to assess a penalty based on medical bills which remained unpaid at the time of claim acceptance, but which had been paid prior to hearing. After further consideration, we agree with the Referee that a penalty pursuant to ORS 656.262(10) is appropriate, and should be based on amounts due at the time of the insurer's acceptance of the claim; however, we base our conclusion on the following analysis.

In our original order, we reasoned that since the claim had been accepted prior to hearing and no compensation remained owing, there were no amounts due at the time of hearing on which to base a penalty. In reaching this conclusion, we cited our decision in Kim S. Jeffries, supra, which held that when the issue concerns the reasonableness of a denial, the penalty is assessed as of the time of the hearing.

Subsequent to the date of our order, the court issued its decision in Conagra, Inc. v. Jeffries, 118 Or App 373 (1993). In Jeffries, the claimant had requested a hearing from the carrier's denial. Subsequent to the hearing, but before the referee had issued an order, the parties settled the claim. Specifically, the carrier agreed to accept and process the claim. The parties further agreed to submit the "unreasonable denial" issue to the referee. The referee found that the carrier's denial was unreasonable and assessed a penalty based on unpaid medical services due as of the date of the denial. We affirmed the referee, but stated that the penalty should be assessed on compensation due as of the hearing.

The Jeffries court has reasoned that a carrier is not statutorily required to pay medical benefits before or after it denies a claim. See ORS 656.262(2),(6). Nevertheless, the court has further concluded that if it is subsequently determined that a claim was improperly denied, any benefits that become due as a result of the setting aside of the denial are considered to be due as of the date the denial is set aside. Since our order in Jeffries assessed penalties based on the date of hearing rather than on the date the denial was withdrawn (the date of the post-hearing stipulation), the court remanded for reassessment of the penalty.

Here, the insurer argues that Jeffries is distinguishable because that case involved a denied claim and a subsequent withdrawal of the denial. Asserting that this case involves a "de facto" denial issue which was not raised at hearing, the insurer argues that a penalty is not assessable. We disagree with both contentions.

The failure to accept or deny a claim within 90 days constitutes a "de facto" denial of the claim. Barr v. EBI Companies, 88 Or App 132 (1987); Lisa A. Hyman, 44 Van Natta 2516 (1992) (on recon). Here, claimant requested a hearing raising the "de facto" denial as an issue. The Referee also framed the issues at hearing as entitlement to a penalty for the insurer's unreasonable delay in accepting/denying and an unreasonable denial of the claim. (Tr. 2). The insurer agreed with this statement of the issues.

The Referee found that, because of its failure to accept or deny the claim within 90 days, the insurer had unreasonably denied benefits and continued to unreasonably delay payment of claimant's compensation. Under the circumstances, we find that this matter involved a "de facto" denied claim and that the denial issue was raised before the Referee.

Relying on Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992), the insurer argues that a penalty is not appropriate. In Smith-Sanders, the insurer orally authorized surgery, but later denied the claim. The claimant requested a hearing from that denial, contending that the insurer was estopped from subsequently denying the surgery. On Board review, we held that the insurer was liable for the expenses of the claimant's surgery under the doctrine of equitable estoppel. In addition, we assessed a penalty for an unreasonable denial. The court affirmed that portion of our order which found that the insurer was estopped from denying the claim, but reversed the award of penalties for an unreasonable denial.

In reaching its decision, the Smith-Sanders court reasoned that medical expenses are not considered "compensation" pending acceptance or denial of a claim. It further reasoned that the insurer's failure to pay or delay in paying medical benefits before it had accepted or denied a condition could not support an award of penalties. Since the claimant's condition had not been properly accepted or denied at the time of the surgery, the Smith-Sanders court held that surgery expenses were not compensation under ORS 656.262(10) and could not support an award of penalties.

In Jeffries, as in Smith-Sanders, the claimant's surgery expenses were also not properly accepted or denied at the time they were incurred. Yet, the Jeffries court held that the key date for determining amounts due is the date the denial is set aside. In other words, the claimant's surgery expenses became an amount "then due" for purposes of assessing a penalty at the time the denial was withdrawn.

Under the Smith-Sanders holding, however, the key date for determining amounts due would appear to be the date the medical service is actually performed. The Jeffries court did not discuss Smith-Sanders or the decision cited in Smith-Sanders, (Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989)). Nevertheless, the Jeffries reasoning expressly rejects the Smith-Sanders analysis. Specifically, the Jeffries court stated:

> "Employer argues that, because no medical benefits are due before the claim is denied, ORS 656.262(6), and because a denial terminates any obligation to make further payments on the claim, ORS 656.262(2), its obligation to pay benefits did not begin until after the stipulation withdrawing the denial.
>
> "Employer's argument begs the question. Although as a procedural matter, an employer is not required to pay medical benefits before or after it denies a claim, if it is subsequently determined that the claim was improperly denied, any benefits that become due as a result of the setting aside of the denial are considered to be due as of the date the denial is set aside." Jeffries, supra (slip op. at 2).

Inasmuch as the Smith-Sanders holding is based on the "procedural" reasoning which has subsequently been rejected by the court, we rely on the Jeffries decision. In any event, since Jeffries is the court's most recent pronouncement concerning this issue, we are bound to follow it. See Libby v. Southern Pac. Co., 109 Or 449, 459 (1923).

Turning to application of the Jeffries holding, we reach the following conclusions. The insurer had determined that the claim was compensable by December 4, 1990. However, the insurer did not accept the claim until June 28, 1991, after claimant's April 22, 1991 hearing request concerning a "de facto" denial and before the December 31, 1991 hearing. For the reasons set forth in the Referee's order and our prior order, we conclude that the insurer's "de facto" denial of benefits and its delay in accepting the claim were unreasonable.

In accordance with the court's reasoning in Jeffries, we agree with the Referee's penalty assessment based on all compensation, including medical services. This penalty shall be based on all compensation due as of the insurer's June 28, 1991 acceptance, rather than as of the December 31, 1991 hearing. Finally, we hold that a 10 percent penalty based on these outstanding medical bills (which total approximately $175,384.87) constitutes adequate punishment for the insurer's unreasonable conduct. In light of this conclusion, it follows that claimant is not entitled to an attorney fee award. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Consequently, we withdraw our $1,000 attorney fee award.

Since penalties do not constitute compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review or reconsideration. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, on reconsideration of our February 2, 1993 order, as supplemented herein, we affirm the Referee's order dated April 14, 1992, as reconsidered on June 5, 1992.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LISA D. HENDERSON, Claimant**
WCB Case No. 92-03276
ORDER ON REVIEW
John Mayfield, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Mills' order which set aside its denial of claimant's claim for low back and right foot injuries. On review, the issue is whether the injury occurred in the course and scope of employment. We reverse.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his first finding of ultimate fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was required to eat lunch off the employer's premises. Relying on our holding in Fred H. Jacobson, 43 Van Natta 1420 (1991), the Referee found that claimant's injury occurred in the course and scope of her employment.

In Fred H. Jacobson, supra, the claimant's job required him to eat lunch away from the employer's premises. There, the claimant was injured during his unpaid lunch hour while eating lunch at a restaurant when the stool on which he was sitting collapsed. We held that, when the nature of the work requires the worker to eat lunch off the premises, injuries that occur during lunch are anticipated risks of the employment and are in the course of the employment. Thus, we found the claim compensable.

SAIF argues that claimant's supervisor only recommended that claimant leave the employer's premises during her unpaid lunch hour. Thus, SAIF argues, claimant was not required to leave the premises. In any event, even assuming that claimant was required to leave the employer's premises during her lunch hour, that fact is not dispositive, given the subsequent history of Jacobson. Subsequent to the Referee's decision, the Court of Appeals reversed our holding in Fred H. Jacobson. PP&L v. Jacobson, 117 Or App 280 (1992). Citing SAIF v. Reel, 303 Or 210, 216 (1987), the court stated that "the test for determining whether an off-the-job injury is compensable is whether the activity causing the injury is an 'integral' part of the worker's employment." PP&L v. Jacobson, supra at 117 Or App 284.

The court held that the fact that a worker is required to eat away from the employer's premises did not, in itself, determine that eating lunch was part of his employment. Id. Instead, the court found that the terms of the employment controlled. There, the union contract provided the claimant with a one hour unpaid lunch break during which the claimant was free to do whatever he chose. Id. Because the employer exercised no control over what the claimant did during his lunch hour, the court found that the lunch activities were purely personal and outside the course of his employment. Id.

Here, even assuming that claimant was required to eat away from the employer's premises, the employer exercised no control over what claimant did during her unpaid lunch hour. Thus, claimant's lunch activities were purely personal and outside the course of her employment. PP&L v. Jacobson, supra.

However, claimant argues that the injury occurred on the employer's premises because the employer had control over the place in which the injury occurred. If that is the case, that fact would distinguish the present case from PP&L v. Jacobson, supra, where the employer had no control over the place of injury.

If an injury has a sufficient relationship to work, it is compensable. Rogers v. SAIF, 289 Or 633 (1980). Injuries occurring while coming to and going from work are ordinarily not work related, and hence, not compensable, unless the employer exercises some actual control over the place where the injury is sustained. Cope v. West American Ins. Co., 309 Or 232, 239 (1990); Janet V. Dollens, 42 Van Natta 2004 (1990); Sheri V. Hiltner, 42 Van Natta 1039 (1990). Control is manifested by employer ownership or maintenance; see Montgomery Ward v. Cutter, 64 Or App 759 (1983); employer actions; see Montgomery v. SIAC, 224 Or 380 (1960); or the presence of employer created special hazards. See Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971).

Claimant does not contend, and we find no evidence that, there were employer actions or the presence of any employer created special hazards that would manifest employer control of the common areas, including the elevators. Also, the employer does not own these common areas. Therefore, the only possible manifestation of control is the question of maintenance.

Here, the employer leases space on the fourth floor of a four floor multipurpose commercial office building. The employer, its customers, and its employees have the right to use the common areas, including the lobby, stairs, and elevators. The owner of the building has responsibility for maintaining the common areas. Claimant was injured while leaving for lunch when she stepped out of the elevator onto the first floor lobby. Claimant was unaware that the elevator had stopped approximately two feet above the level of the first floor; as a result, she fell and injured her low back and right foot.

Claimant relies on two cases to support her contention that the injury occurred on the premises of the employer. First, she states that Cope v. West American Ins. Co., supra, held that "an employee [who was] injured while walking to work from a leased parking lot across a public street was located on the employer's premises for purposes of worker's [sic] compensation." (Respondent's Brief, p.4). Claimant misreads Cope. In Cope, the parties conceded both that the employee was on the public sidewalk at the time of the injury and that the employer had no control over the public sidewalk. Id. at 309 Or 239. The Supreme Court declined to extend the "parking lot rule" to include such circumstances and held that some form of employer control of the area where the injury occurred was required to prove the work-connection necessary to make the injury compensable. Id. at 309 Or 239-240.

Thus, Cope does not support claimant's argument that the injury occurred on the employer's property because it "occurred in an area leased as part of the egress from the work station by the employer for the use of its employees." (Respondent's Brief p.4). The fact that the lease gave the employer and its employees the right to use the common areas does not determine that the employer had the requisite control over the common areas.

Second, citing Montgomery Ward v. Cutter, supra, claimant argues that the employer exercised control over the area in which the injury occurred because it could require the owner to make repairs. We disagree. In Cutter, supra, the employer leased a retail outlet in a shopping mall and an automotive outlet located in a separate building from the main mall area. There, while returning to work from her lunch hour, the claimant stepped in a hole in the mall parking lot and injured her ankle. The employees were required to park in a certain part of the mall parking lot, and the claimant fell in an area through which she was required by her work to travel repeatedly on a daily basis. Finally, the employer could have required the shopping mall to repair the hole. Id. at 64 Or App 762. The court found that, under these facts, the portion of the parking lot where claimant fell was sufficiently within the employer's control to be considered part of the employer's premises. Id. at 64 Or App 762-763.

We find Cutter distinguishable on the facts. Here, claimant was not required to use the elevator, she could have used the stairs. All of claimant's work activities as an accounts payable clerk took place in the employer's offices on the fourth floor. There is no evidence that she was required by her work to go to other floors repeatedly during the day. Finally, the employer could not require the owner to make repairs to the common areas, including the elevators.

The lease provides that the landlord "shall maintain in good condition and repair . . . all of the common areas." (Ex. 7-1). Thus, the landlord was responsible for maintaining the common areas. The lease also provides that the landlord "shall have no obligation to make repairs . . . until a reasonable time after receipt of written notice from Tenant of the need for such repairs." Id. Finally, the lease states that the "Tenant hereby waives any right it may have under applicable law to vacate the Premises or terminate this Lease upon Landlord's failure to make any repairs." Id. Based on the terms of the lease, the employer could not require the landlord to repair the elevator.

Claimant's supervisor testified that the employer had repeatedly notified the landlord that the elevators were not operating properly. (Tr. 18-19). She also testified that the employer could not hire someone on its own to repair the elevators. (Tr. 19).

Thus, The employer did not own the building, was not responsible for maintaining the elevator, and could not require the landlord to repair the elevator. Actual control by the employer of the area of injury is necessary to establish control. Cope, supra: Janet V. Dollens, supra. 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; (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.

Claimant's lunch break was of slight benefit to the employer in that the employer secured a more relaxed employee as a result of lunch breaks. Sheri V. Hiltner, supra. Lunch breaks away from the office were contemplated by the parties, as evidenced by the supervisor's request that claimant not eat lunch at her desk.

Claimant argues that leaving the building for an employer requested lunch break away from the building by means of known defective elevator is an ordinary risk of, and incidental to, her employment. We disagree. The fact that claimant was required to eat away from the employer's premises does not make eating lunch incidental to her employment. PP&L v. Jacobson, supra. Also, claimant was not required to use the elevator. In addition, claimant was free to do whatever she wished during her lunch hour; the employer had no control over her activities during that time. PP&L v. Jacobson, supra; Sheri V. Hiltner, supra. Under these circumstances, we conclude that claimant was not engaged in an activity incidental to her employment when she used the elevator to go to lunch.

Claimant was not paid for her lunch breaks. Relying on Cope v. West American Ins. Co., supra, and Montgomery Ward v. Cutter, supra, claimant argues that her injury occurred on the employer's premises. We addressed those arguments above and concluded that the common areas, including the elevator, were not part of the employer's premises because they were not within the employer's control. Furthermore, the employer does not own the elevator, is not responsible for maintaining it, and did not create any special hazards in it. Sheri V. Hiltner, supra. Therefore, we find that claimant's injury did not occur on the employer's premises.

Claimant's supervisor recommended that claimant leave the office during her lunch break. Thus, the employer at least acquiesced in claimant's leaving the office for her lunch break.

Claimant argues that she was not on a personal mission because: (1) she was complying with the request of her employer to take her lunch away from the office; and (2) the injury occurred on the employer's premises. We disagree. The fact that claimant was requested to eat lunch away from the office does not make that activity work related. PP&L v. Jacobson, supra. In addition, we have concluded that the injury did not occur on the employer's premises. There is no allegation or proof that claimant was engaged in any employment related activity. We conclude that she was on a personal mission when she was injured.

In combination, the factors preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Claimant was not engaged in an activity incidental to her work, was not being paid, was not on her employer's premises, and was on a personal mission. While the activity was of slight benefit to the employer, and contemplated by and acquiesced to by her employer, we consider these lessor considerations insufficient to establish the work connectedness of claimant's injury. Sheri V. Hiltner, supra.

ORDER

The Referee's order dated June 19, 1992 is reversed. The SAIF Corporation's denial is reinstated and upheld. That portion of the order which awarded claimant a $2,000 assessed attorney fee is reversed.

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March 30, 1993 Cite as 45 Van Natta 562 (1993)

In the Matter of the Compensation of
**JAN L. JACKMAN, Claimant**
WCB Case No. 91-14654
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Holtan's order that: (1) increased his scheduled permanent disability award for a right foot condition from 24 percent (32.4 degrees), as awarded by an Order on Reconsideration, to 28 percent (37.8 degrees); (2) increased his scheduled permanent disability award for a left foot condition from 31 percent (41.85 degrees), as awarded by an Order on Reconsideration, to 35 percent (47.25 degrees); (3) directed that the scheduled disability awards be paid at the rate of $145 per degree; and (4) assessed penalties pursuant to ORS 656.268(4)(g). The SAIF Corporation cross-requests review of the order. On review, the issues are extent of scheduled permanent disability, rate of scheduled disability, and penalties.

Neither party submitted briefs to explain their respective positions on review. However, after considering the record on de novo review, we affirm and adopt the Referee's order with the following supplementation.

The Referee relied on ORS 656.268(4)(g) in affirming a 25 percent penalty awarded by the Order on Reconsideration on the basis that claimant was at least 20 percent disabled and his compensation was increased by at least 25 percent beyond the amount awarded pursuant to SAIF's Notice of Closure. The Referee concluded that OAR 436-30-050(14), which provided an exception to the automatic penalty when the increased award was due to a medical arbiter's report, was without effect because it was inconsistent with the clear language of ORS 656.268(4)(g) and exceeded the Director's statutory authority. We agree. In Kevin Northcut, 45 Van Natta 173 (1993), we recently decided this issue on the same bases as used here by the Referee.

SAIF cross-requested review of the Referee's order, presumably disputing, in part, the increase in scheduled permanent disability, and we did not reduce that award. Therefore, claimant might have been entitled to an attorney fee on review 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 he is not entitled to an attorney fee. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 15, 1992 is affirmed.

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In the Matter of the Compensation of
**JOHN C. LEYES, Claimant**
WCB Case No. 92-03566
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee McWilliams' order that increased claimant's unscheduled permanent disability award for an upper back and neck injury from 13 percent (41.6 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees). Claimant cross-requests review, asserting entitlement to an assessed attorney fee. On review, the issues are extent of unscheduled permanent disability and attorney fees. We modify in part and affirm in part.

We affirm and adopt the Referee's order, with the following comment and modification.

The employer argues that claimant may not now raise the question of his entitlement to an assessed attorney fee because he did not raise it at hearing. However, the question of claimant's entitlement to an assessed fee did not arise until the Referee failed in her order, to award claimant a fee for prevailing over the employer's request to reduce the permanent partial disability award. Accordingly, the fee question is properly presented on review.

The Referee authorized a fee payable out of the increased permanent disability compensation due under her order. Although claimant's compensation was not reduced pursuant to the employer's request, (see Tr. 2), the Referee did not award an assessed fee. Claimant contends that an employer-paid fee should have been awarded under OAR 438-15-065. We agree. See ORS 656.382(2); Kordon v. Mercer Industries, 308 Or 290 (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 attorney's services at hearing concerning the employer's request for reduced compensation is $500, 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 the hearing record), the complexity of the issue, and the value of the interest involved.

In addition, 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 permanent disability issue is $300, 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. Finally, we note that claimant is not entitled to an attorney fee for his efforts concerning the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 17, 1992 is affirmed in part and modified in part. That portion of the order that did not award an assessed attorney fee is modified. Claimant's counsel is awarded an assessed attorney fee of $500 for defending claimant's award of compensation at hearing, payable by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $300, payable by the self-insured employer.

In the Matter of the Compensation of
**JAMES A. MAURATT, Claimant**
WCB Case No. 92-02523
ORDER ON REVIEW
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband, Brazeau, and Gunn.

Claimant, pro se, requests review of Referee Crumme's order that upheld the insurer's denial of his claim for a low back injury. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated June 11, 1992 is affirmed.

**Board Member Gunn specially concurring.**

I concur with the majority's legal conclusions. I write only for the benefit of the pro se claimant. Claimant has clearly invested a great deal of time and energy in his appeal. As a lay person, he should understand our reasons for judgment and a simple affirm and adopt opinion might deprive him of that understanding.

To the claimant, you are identified as a "pro se" claimant which is legal latin for the fact you are representing yourself without a lawyer. Your case which includes the transcript of the hearing and all the evidence submitted at hearing was reviewed by a staff attorney and three Board members. The Board members review the record (the hearing transcripts, exhibits, and memoranda and draft orders issued by the staff attorneys). When two of the three Board members agree on a case, they issue an Order on Review. The Order on Review is then reviewed by other staff attorneys and a final Order on Review is produced. The Board members sign the order and send it out. In your case, we are issuing an "affirm and adopt" of the Referee's order. This means we agree with the determination of the Referee (the man you refer to as the judge). In this case, I am writing separately to explain the process and why I at least reached the decision to affirm and adopt the Referee's order.

To understand how I reached my decision, you have to understand the Workers' Compensation law and how the legal judicial process directs us to reach our judgments. It is a judicial system and as in many systems it strives for consistency and sometimes ignores common sense and reality.

The law requires that you as the claimant must prove all elements of your claim. ORS 656.266 states:

> "Burden upon worker to prove compensability and nature and extent of disability. The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

The law requires you have the burden of proof. And it is truly a burden. You must prove based on the evidence in the record (all the testimony and documents presented at the hearing) that an accidental injury did occur. You have to prove that it is more likely than not that the injury occurred when, where, and how you say it did.

In this case, given the inconsistencies between your testimony and the log books, you are unable to prove it is more likely than not that the injury occurred.

I understand your statements about log books and pressures exerted by trucking companies on their drivers. As a former state weightmaster, I am not ignorant of those pressures. The problem is the law requires you to prove those assertions. On this record, you cannot prove those assertions. Although I know they can occur, you are required by law to prove it.

Please understand it is not that I think you are lying or that the events you describe did not occur. The law requires you to prove it and the conflict between your discrepancies and the physical evidence of the log books is too great for you to meet your burden of proof.

For these reasons, I must agree with my colleagues and find against you having a compensable injury.

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March 30, 1993 Cite as 45 Van Natta 565 (1993)

In the Matter of the Compensation of
**MARVIN L. THRASHER, Claimant**
WCB Case No. 92-02339
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Montgomery Cobb, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Lipton's order that declined to increase his award of scheduled permanent disability for a left knee injury beyond the 6 percent (9 degrees) awarded by an Order on Reconsideration. The insurer requests that claimant's request for review be dismissed on the basis that the appeal is rendered moot by the Department of Insurance and Finance's abatement and reissuance of the Order on Reconsideration. On review, the issues are dismissal and extent of scheduled permanent disability. We deny the motion to dismiss and affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

We take administrative notice of the fact that on January 6, 1993, the Department of Insurance and Finance issued an "Order Abating and Reissuing" its April 14, 1992 Order on Reconsideration. The January 6, 1993 order abated the April 14, 1992 Order on Reconsideration to reevaluate the extent of claimant's permanent disability in light of the promulgation of OAR 436-35-230(13). The January 6, 1993 order found that claimant was not entitled to an impairment value pursuant to ORS 436-35-230(13) because there was no strength loss, effusion, varus or valgus deformity or grade IV chondromalacia in claimant's left knee as a result of the injury.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Dismiss

The insurer moves to dismiss claimant's request for review on the basis that the Department of Insurance and Finance's January 6, 1993 abatement and reissuance of its April 14, 1992 Order on Reconsideration renders claimant's appeal moot. We disagree.

Recently, in Kenneth G. Moore, 45 Van Natta 16 (1993), we held that the fact that the Department abates and withdraws an Order on Reconsideration, while Board review is pending, does not render the issue raised on review moot. Consequently, claimant's request for review concerning the extent of his permanent disability is properly before the Board. Therefore, in accordance with the rationale expressed in Moore, supra, we deny the insurer's motion to dismiss claimant's request for review.

### Extent of Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning with the following supplementation.

The Referee concluded that he did not have authority to promulgate rules addressing claimant's disability. We agree and adopt his conclusions and reasoning concerning that issue. See Gary D. Gallino, 44 Van Natta 2506 (1992) (Board does not have the authority to remand an Order on Reconsideration to the Director to determine whether claimant's chondromalacia condition is addressed by the standards).

Nevertheless, the Director has now adopted a rule to provide for impairment due to chondromalacia where the injured worker has grade IV chondromalacia, secondary strength loss, chronic effusion, varus or valgus deformity, or a chronic condition. Here, Dr. Farris reported that claimant had extensive generalized chondromalacia in the left knee. There is no evidence that claimant has chronic effusion, secondary strength loss or a varus or valgus deformity. Moreover, although Dr. Farris reported that claimant has extensive generalized chondromalacia, Dr. Farris does that state that it is grade IV.

Inasmuch as Dr. Farris' report is not in conformance with the requirements of OAR 436-35-230(13)(a)-(b), his report is not persuasive evidence. See Michael E. Cooney, 45 Van Natta 155 (1993). Accordingly, claimant is not entitled to an impairment value pursuant to OAR 436-35-230(13)(a)-(b); Gallino, supra.

ORDER

The Referee's order dated May 29, 1992 is affirmed.

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March 31, 1993 Cite as 45 Van Natta 566 (1993)

In the Matter of the Compensation of
**FLOR IRAJPANAH, Claimant**
WCB Case No. 92-05366
ORDER ON REVIEW
Eileen G. Simpson, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of those portions of Referee Mills' order which: (1) set aside its denial of claimant's current low back condition; and (2) found claimant's low back injury claim had been prematurely closed. On review, the issues are compensability and premature closure. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee on the issue of compensability of claimant's low back condition.

Premature Closure

We affirm and adopt the Referee on the issue of premature closure with the following supplementation.

The Referee found that claimant was not medically stationary in August 1991, the date provided for on the Determination Order. He, therefore, concluded that the October 1991 Determination Order prematurely closed claimant's claim. We agree with the Referee's result but offer the following analysis.

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).

Claimant's condition did not change after the October 1991 closure and the only question is whether claimant was medically stationary at the time of closure. Therefore, in evaluating whether claimant's claim was prematurely closed, we may consider post-closure medical reports. Scheuning v. I.R. Simplot & Co., 84 Or App 622 (1987).

The medical evidence indicates that claimant continued to seek treatment for her symptoms after claim closure. Further, Dr. Noall, her treating physician, believed claimant would benefit from further evaluations. After these evaluations were performed, Dr. Wong, claimant's current treating physician, offered treatment that had not been proposed before, and did so with a reasonable hope of further medical improvement. Drs. Noall and Cline concurred with Dr. Wong's opinion. Accordingly, we agree with the Referee that claimant's condition was not medically stationary on the date of closure. See Scheuning v. I.R. Simplot & Company, supra.

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 for

claimant's counsel's services on Board review concerning the compensability and premature closure issues, a reasonable assessed fee is $1,000, 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 July 29, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee in the amount of $1,000, to be paid by the self-insured employer.

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March 31, 1993 Cite as 45 Van Natta 567 (1993)

In the Matter of the Compensation of
**EVERY MENDENHALL, Claimant**
WCB Case Nos. 91-10150, 89-24635 & 91-05946
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of those portions of Referee Peterson's order that: (1) declined the insurer's motion to continue the hearing; (2) set aside its May 6, 1991 partial denial of claimant's low back condition; (3) set aside that portion of its June 7, 1991 amended denial denying claimant's low back conditions at L3-4 and L4-5 and upheld that portion denying claimant's low back condition at L5-S1 and right antalgia; (4) increased claimant's unscheduled permanent disability award for a cervical condition from 53 percent (169.6 degrees), as awarded by a Determination Order, to 66 percent (211.2 degrees); and (5) increased claimant's unscheduled permanent disability award for a low back condition from 13 percent (41.6 degrees), as awarded by Determination Order, to 43 percent (137.6 degrees). On review, the issues are motion to continue, compensability and extent of unscheduled permanent disability. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant initially requested a hearing on a July 13, 1989 Determination Order. The claim was reopened prior to hearing, and then reclosed by a May 17, 1991 Determination Order which was affirmed by a September 4, 1991 Order on Reconsideration. Claimant's hearing request on that Order on Reconsideration was consolidated with the earlier hearing request.

The hearing on the denials was originally set for August 8, 1991. On August 14, 1991, it was reset for October 30, 1991. On September 3, 1991, the insurer sent claimant a letter scheduling an independent medical examination (IME) for October 8, 1991. Claimant, who had been laid off from work, had given notice at his apartment and was in the process of moving out of state. On September 5, 1991, claimant notified the insurer of his move and provided his new address, explaining that he was financially unable to remain in Oregon for the October 8, 1991 IME. (Ex. 96-F). The insurer cancelled the IME on October 3, 1991. (Ex. 105-3).

On October 17, 1991, the insurer requested that the hearing be postponed so that claimant could attend an IME with Dr. Fuller. Another referee denied the request. On October 18, 1991, a different independent medical examiner notified claimant that another IME had been scheduled for October 29, 1991, at 3:00 pm. Claimant, who had purchased a non-refundable airline ticket, was scheduled to arrive in Oregon after 3:00 pm. He informed the insurer that he was unable to attend the IME.

FINDINGS OF ULTIMATE FACT

Claimant's December 30, 1990 injury combined with claimant's preexisting low back condition. The injury is the major contributing cause of claimant's current disability and need for treatment.

Claimant has sustained a 61 percent loss of earning capacity as a result of his neck injury. Claimant has sustained an additional 13 percent loss of earning capacity as a result of his low back injury.

## CONCLUSIONS OF LAW AND OPINION

### Evidentiary Issue

A Referee "may continue a hearing . . . for any party to respond to an issue raised for the first time at a hearing; or . . . [f]or any reason that would justify postponement of a scheduled hearing under 438-06-081." See OAR 438-06-091(3) and (4). A Referee shall not postpone a hearing "except upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement." See OAR 438-06-081. Here, the Referee declined to grant the insurer's motion for a continuance.

At the beginning of the hearing, the insurer requested a continuance to keep the record open, based on claimant's alleged failure to attend an independent medical examination (IME). Shortly thereafter, claimant raised the issue of the scope of acceptance as a new issue. The insurer made no objection to the new issue. At the end of the hearing, the Referee declined to grant the insurer's motion for a continuance for the reasons that a prior referee had already ruled that a postponement should not be allowed, based on the same factual issues; the basis for the request was incorrect; and the insurer was dilatory in requesting an IME. (See Tr. 81-84.)

On review, the insurer argues that the Referee erred in not granting a continuance based on the introduction of a new issue and extraordinary circumstances beyond the insurer's control in its inability to obtain an IME. We disagree. First, the insurer did not object to the introduction of a new issue and did not request the continuance on that basis. Second, as the language of OAR 438-06-091 is permissive, the authority to continue a hearing rests within a referee's discretion. OAR 438-06-091; Sue Bellucci, 41 Van Natta 1890 (1989); see Randy L. Kling, 38 Van Natta 1046 (1986). The Referee had statutory authority to conduct the hearing in any manner that would achieve "substantial justice." See ORS 656.283(7).

The insurer was aware by early September that claimant was unable to attend the October 8th IME. The insurer did not reschedule the IME until October 18th, less than two weeks prior to the hearing and for a time prior to claimant's already-established arrival in Oregon. It has offered no explanation for that delay. We conclude that the Referee did not abuse his discretion by denying the motion for a continuance, because there were no extraordinary circumstances beyond the control of the insurer. See OAR 438-06-091(4) and 438-06-081.

### Compensability

The Referee set aside the insurer's May 6, 1991 partial denial in its entirety and that portion of its June 7, 1991 denial which denied claimant's low back conditions at L3-4 and L4-5. He upheld that portion of the June 7, 1991 denial which denied claimant's L5-S1 condition and right antalgia. The insurer contends that the Referee erred in setting aside its partial denial of claimant's preexisting low back condition at L3-4 and L4-5. We disagree.

The May 6, 1991 partial denial states:

> "We have accepted your date of injury of December 30, 1990 for low back strain only. Medical information indicates you have a condition pre-existing this date of injury. Therefore, we are issuing this partial denial for your stenosis at L3-4, foraminal stenosis at L4-5 and bulging disk at L3-4."

The June 7, 1991 denial amending the May 6, 1991 denial states:

> "This denial letter amends the denial of May 6, 1991. Pursuant to Notice of Acceptance dated May 6, 1991, we have accepted your low back strain of December 30, 1990. However, there is no medical evidence that the injury of December 30, 1990 or your work at Reynolds Metals is the major contributing cause of any other condition which exists in your lumbar spine.
>
> "We are therefore denying all pre-existing conditions in your lumbar spine including but not limited to stenosis at L3-4, foramina (sic) stenosis at L4-5, bulging disk at L3-4, ruptured disks in the lumbar spine, degenerative disease in the lumbar spine, disk protrusion at L3-4, bulging disk at L5-S1, right antalgia and limp, and all symptoms caused by these conditions. Your low back strain remains in its accepted status . . . ." (Emphasis added.)

Claimant experienced an injury to his low back on December 30, 1990. This injury was accepted by the insurer as a "low back strain." The injury manifested itself as pain in the right lumbar region radiating to the right buttock and leg and severe right antalgia and limp. It resulted in disability and the need for treatment. (Ex. 74). Dr. Berkeley, claimant's treating neurosurgeon, diagnosed preexisting degenerative changes in his lumbar spine at L3-4 and L4-5 which were asymptomatic until the injury was superimposed on the preexisting condition. Claimant was never diagnosed with a low back strain.

We interpret Dr. Berkeley's diagnosis to mean that the injury combined with claimant's preexisting disease to cause disability. Consequently, in order to establish the compensability of his current low back condition, claimant must prove that the injury is the major contributing cause of his disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

In this case, the record establishes that claimant experienced a low back injury on December 30, 1990. That injury was accepted by the insurer. (Ex. 89). The medical record supports Dr. Berkeley's opinion that claimant's preexisting low back condition was asymptomatic until the injury. Dr. Berkeley also opined that the injury was the major contributing cause of claimant's disability and need for treatment. (Ex. 83). There is no contrary opinion. Accordingly, we conclude that claimant's current symptomatic low back condition, which resulted from the combination of his injury and preexisting disease, is compensable. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

Consequently, given the language in the denial that denies "all symptoms caused by these conditions," we must set aside the denials in their entirety.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of the compensability of the right antalgia and L5-S1 conditions. 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 the right antalgia and L5-S1 conditions is $1,000, 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 appellate brief), the complexity of the issue, and the value of the interest involved. This fee is in addition to the Referee's carrier paid attorney fee award.

Extent of Unscheduled Disability

Neck

Claimant initially requested a hearing on a July 13, 1989 Determination Order. The claim was reopened prior to hearing, and then reclosed by a May 17, 1991 Determination Order which was affirmed by a September 4, 1991 Order on Reconsideration. Claimant's hearing request on that Order on Reconsideration was consolidated with the earlier hearing request. In such a case, we apply the standards in effect on the date of the May 17, 1991 Determination Order. See Wade A. Webster, 42 Van Natta 1707 (1990). Furthermore, since the July 13, 1989 Determination Order is not a final award or arrangement of compensation, comparison of claimant's condition at the time of the May 17, 1991 Determination Order with claimant's condition at the time of the July 13, 1989 Determination Order is not appropriate. Susannah Rateau, 43 Van Natta 135 (1991). See also OAR 436-35-007(5).

The insurer contends that the Referee's award for surgical procedures relating to the same body part were excessive. We disagree.

The Director has adopted standards for the evaluation of disabilities pursuant to ORS 656.726(3)(f) at OAR 436-35-001 et seq. The rules in effect on the date of the Notice of Closure or Determination Order control. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003. In this case, the applicable rules are those in effect on May 17, 1991, the date the Determination Order issued, which are contained in WCD Administrative Order 2-1991, effective April 1, 1991.

Former OAR 436-35-350(2) provides that the values for surgically treated spinal disorders resulting from work injuries are determined under subsection (a) for surgical procedures resulting from intervertebral disc lesions, or under subsection (b) for surgical procedures resulting from spinal stenosis and/or segmental instability. To be considered under subsection (b), the worker must have a specific diagnosis of spinal stenosis and/or segmental instability. Former OAR 436-35-350(2)(b)(A). If a fusion is part of the surgical procedure for instability, no additional value is given beyond that in subsection (b) combined with the values for range of motion. Former OAR 436-35-050(3)(b)(B).

Here, claimant was diagnosed with a herniated disc at C4-5, which was decompressed and fused on August 5, 1988. (Ex. 7). There was no diagnosis of stenosis or instability. Accordingly, claimant receives a value of 7 percent for this first surgical procedure on a single cervical disc. Former OAR 436-35-350(2)(a).

Claimant was also diagnosed with a herniated disc without stenosis or instability at C6-7, which was decompressed and fused on December 21, 1988. (Ex. 22). Because this surgical procedure did not involve the same intervertebral disc as the first procedure, claimant is entitled to have the surgery rated as a first surgical procedure. Accordingly, claimant receives a value of 7 percent for this first surgical procedure on a single cervical disc. Former OAR 436-35-350(2)(a).

On February 19, 1990, claimant was diagnosed with postoperative changes at C4-5, which caused canal stenosis, and C6-7, with a disc bulge and foraminal stenosis at C5-6. A discectomy and fusion was performed at C5-6 and a decompression and re-fusion at C4-5. (Exs. 46 and 51). Again, because the surgical procedure at C5-6 did not involve the same intervertebral discs as the prior procedures, claimant is entitled to have the surgery rated as the first surgical procedure. For the first surgical procedure resulting from spinal stenosis at C5-6, the value is 8 percent. Claimant is also awarded 1 percent for any additional vertebra, here the C4-5 decompression and re-fusion, treated within the same body part. Former OAR 436-35-050(2)(b).

Values within one body part for surgically treated spinal disorders are added. Former OAR 436-35-350(2). Accordingly, the value for claimant's cervical surgeries is 23. In order to rate range of motion loss and surgery in one body part, we combine the total range of motion loss, here 10 percent, with the total surgical impairment value in the same body part. Former OAR 436-35-050(23). The resulting impairment value for claimant's cervical region is 31 percent.

A determination of unscheduled permanent disability under the standards is made by determining the appropriate values assigned by the standards to the worker's age, education, adaptability and impairment. The product of the non-impairment values, here an undisputed 30 percent, is added to the 31 percent impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280. Accordingly, the percentage of unscheduled permanent partial disability for the neck condition is 61 percent.

Application of ORS 656.214(5)

The insurer also contends that the Referee's award of an additional 30 percent unscheduled disability for age, education and adaptability in the low back claim was excessive, since these factors were already compensated by the neck award. We agree. Although the Referee correctly computed the value for claimant's low back disability, the analysis does not end there.

ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. 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. Mary A. Vogelaar, 42 Van Natta 2846 (1990). This principle applies equally whether a series of accidents involves injury to the same or different unscheduled parts of the body. Id. The methodology is as follows.

We first rate all permanent disability (considering only permanent impairment due to claimant's low back) under the standards; here, the Referee found a total of 43 percent unscheduled permanent disability for the low back condition. We then determine whether, and to what extent, that disability figure includes unscheduled permanent disability (loss of earning capacity) present before the low back injury. Only that portion of lost earning capacity which was not present prior to the current injury shall be awarded. OAR 436-35-007(b). As we emphasized in Vogelaar, supra, this is not a mathematically precise process. Instead, we consider to what extent a prior loss of earning capacity resulted from the same permanent limitations and vocational factors as are relied upon in our subsequent evaluation of permanent disability. We will reduce the award by the amount that represents previously compensated loss of earning capacity.

After claimant's May 5, 1988 worsening in the neck, Dr. Berkeley released claimant to light work on October 24, 1990. The employer subsequently placed claimant back on medium/heavy work, at which time his neck again became symptomatic and he injured his low back. Dr. Berkeley now limits claimant to light work in relation to his low back as well as his neck. (Exs. 74 and 95). We take this

into account in determining the extent to which the prior unscheduled permanent disability award for the neck condition compensated claimant for the same permanent limitations and vocational factors as claimant's present permanent disability award for the back condition.

We conclude that 13 percent of the current award for the back condition, as determined by the standards, represents permanent disability which was not present prior to the 1990 back injury. Therefore, claimant is entitled to an award of 13 percent unscheduled permanent disability as "due to" the 1990 back injury.

ORDER

The Referee's order dated November 14, 1991 is reversed in part, modified in part and affirmed in part. That portion of the order which upheld the May 7, 1991 denial of claimant's low back condition at L5-S1 and right antalgia is reversed. That denial is set aside in its entirety, and the low back claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $1,000 for services at hearing and on Board review, to be paid by the insurer. This fee is in addition to the Referee's carrier paid attorney fee award. That portion of the order that awarded claimant an additional 13 percent (41.6 degrees) unscheduled permanent disability for the neck condition is modified to award an additional 8 percent (25.6 degrees) unscheduled permanent disability, giving claimant a total of 61 percent (195.2 degrees) unscheduled permanent disability for the neck condition. The Referee's out-of-compensation attorney fee award is adjusted accordingly. That portion of the order that awarded claimant an additional 30 percent (96 degrees) unscheduled permanent disability for the low back condition is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**MARY M. SCHULTZ, Claimant**
WCB Case Nos. 91-18452 & 91-13000
ORDER ON RECONSIDERATION
Callahan & Stevens, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Claimant requests reconsideration of our March 3, 1993 Order on Review that: (1) reversed the Referee's order finding that claimant had proved "good cause" for her failure to timely file her request for hearing from the SAIF Corporation's denial and; (2) set aside SAIF's denial of claimant's occupational disease claim for a right and left leg condition.

Claimant's request for reconsideration is granted. We withdraw our prior order. On reconsideration, we adhere to and republish our prior order with the following supplementation.

Relying on SAIF's claims adjuster's testimony, the Referee found that SAIF paid interim compensation to claimant beginning on March 18, 1991, which was prior to the date of "injury". Moreover, the Referee found that claimant was sufficiently confused regarding the status of her claim to prove "good cause" for her failure to timely file her request for hearing. Our order reversed, determining that SAIF did not pay claimant interim compensation commencing on March 18, 1991 and that claimant had not proven "good cause".

In her request for reconsideration, claimant first alleges that the Board was without authority to reject the claims adjuster's testimony, and by doing so, our factual finding as to the beginning date of interim compensation was not supported by the record. We disagree. First, by virtue of our de novo review authority, we are empowered to interpret the record in reaching our decision. We have done so in this case. Second, the Order on Review cited those facts supporting our conclusions regarding the date of commencement of interim compensation. Those facts are taken directly from the documentary and testimonial record.

Next, claimant asserts that, based on the entire record, she proved that she was confused about the status of her claim and that this confusion constituted "good cause." Although claimant's memorandum supporting her request for reconsideration lists various facts to support this contention, we note again that, at hearing, claimant appeared to allege that only the receipt of the interim compensation caused her to become confused. Therefore, in also rejecting this contention, we continue to adhere to the holding that any confusion caused by the receipt of interim compensation is not

sufficient to prove "good cause", Harold D. Wolford, 44 Van Natta 1779, 1780 (1992), and that her lack of diligence in clearing up any confusion also prevents her from successfully demonstrating "good cause," see Cogswell v. SAIF, 74 Or App 234 (1985).

Consequently, claimant's request for reconsideration is granted. On reconsideration, 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.

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March 31, 1993 Cite as 45 Van Natta 572 (1993)

In the Matter of the Compensation of
**ROSEMARY E. SZABO-BERRY, Claimant**
WCB Case No. 89-08806
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

The insurer requests review of Referee Mills' order that set aside its denial of claimant's occupational disease claim for her bilateral inner ear concussion syndrome, including perilymph fistulas, benign paroxysmal positional nystagmus, vertigo and secondary hydrops. Claimant cross-requests review of that portion of the Referee's order which awarded an assessed attorney fee of $3,500 for her counsel's services. On review, the issues are compensability 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

We adopt the Referee's "Conclusions and Opinion" on the issue of compensability.

### Attorney fees

The Referee awarded claimant an assessed attorney fee of $3,500 for her counsel's services at hearing. On review, claimant argues that as a result of our prior Order on Remand, 43 Van Natta 2606 (1991), this is actually the second time the parties have proceeded to hearing on this matter. Claimant contends that the Referee's attorney fee award does not reflect all of her counsel's efforts in the prior proceedings. We agree.

In Cleo I. Beswick, 43 Van Natta 1314 (1991), we concluded that where a claimant had finally prevailed after remand from the court, ORS 656.388(1) provided for an attorney fee award for claimant's counsel's services before every prior forum. In the present case, we conclude that the statute also provides for an attorney fee as claimant finally prevailed over the insurer's denial after remand from the Board. See 656.388(1). Accordingly, we conclude that claimant is entitled to an attorney fee award for her counsel's services before every prior forum, which includes the first hearing regarding the compensability issue that eventually resulted in the Board's Order on Remand.

After considering the factors in OAR 438-15-010(4) and applying them to this case, we find that $6,500 is an appropriate attorney fee for claimant's counsel's services at the prior hearings and in the first Board review. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's statement of services, and the insurer's objections to claimant's statement of services), the complexity of the issue and the value of the interest involved. Accordingly, the Referee's attorney fee award of $3,500 is modified. In lieu of the Referee's award, claimant is awarded an attorney fee of $6,500 for her counsel's services in all prior forums, to be paid by the insurer.

Claimant's counsel is also entitled to an assessed attorney fee for prevailing against the insurer's request for review. ORS 656.382(2). After considering the factors 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 $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 claimant's respondent's brief and statement of services), the complexity of the issue and the value to claimant of the interest involved. We note that no attorney fee for services on review is available for that portion of claimant's counsel's services devoted to the attorney fee issue.

ORDER

The Referee's order dated May 1, 1992 is affirmed in part and modified in part. The Referee's attorney fee award is modified. In lieu of the Referee's award, claimant's counsel is awarded an attorney fee of $6,500, to be paid by the insurer. The remainder of the Referee's order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $2,000, to be paid by the insurer.

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In the Matter of the Compensation of
**ROBERT E. WOLFORD, Claimant**
WCB Case No. 92-00297
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of Referee T. Lavere Johnson's order that: (1) vacated and set aside the insurer's "Notice of Refusal to Close" the claim; (2) directed the insurer to process the claim to closure; and (3) assessed a penalty and attorney fee for unreasonable claims processing. On review, the insurer contends that it had no statutory obligation to close the claim while the disabling or nondisabling status of the claim was pending review. The issues on review are claims processing, penalties and attorney fees. We affirm the Referee's order.

FINDINGS OF FACT

This case was decided on stipulated facts. We adopt those facts, but do not adopt the Referee's findings of fact regarding claimant's permanent impairment.

On March 10, 1993, we affirmed Referee Nichols' September 20, 1991 order, in WCB 91-06988, which reclassified claimant's claim as disabling. Robert E. Wolford, 45 Van Natta 435 (1993). We held that the Hearings Division had jurisdiction to determine the disabling status of claimant's claim, finding that the date of injury, for classification purposes, was the date of claim acceptance. We also reasoned that the Department's letter stating that it lacked jurisdiction over claimant's request for reclassification constituted a final order. Wolford, supra.

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as our prior decision meets the aforementioned standard, we take administrative notice of it.

CONCLUSIONS OF LAW AND OPINION

The Referee determined that except for specific limitations, not relevant here, amended ORS 656.313 did not affect the insurer's processing obligations, including processing a claim, found to be disabling by Opinion and Order, to closure.

The insurer contends that the amendments to ORS 656.313 absolved it of any statutory obligation to close a claim while the reclassification issue was pending review. Contrary to the insurer's contentions, amended ORS 656.313 did not reverse the underlying policy stated in SAIF v. Maddox, 295 Or 448 (1983) to obligate an insurer to process a claim pending appeal. In Maddox, the Supreme Court relied on former ORS 656.313 to hold that the compensability of a claim need not be finally determined before the extent of disability may be determined and litigated. Id. at 454. Amended ORS 656.313

removed the insurer's obligation to pay compensation pending appeal, but it did not absolve the insurer of its ongoing claim processing obligations. As in Maddox, the extent of disability, if any, may be determined before the underlying reclassification issue is finally determined.

Furthermore, we stated in Felipe A. Rocha, 45 Van Natta 47 (1993), that the phrase in ORS 656.313(1)(a), "that accrue from the date of the order appealed from until closure under ORS 656.268," contemplates processing of a claim pending appeal in accordance with the order directing such. We concluded that a carrier was entitled to stay the payment of "pre-litigation order" temporary disability pending its appeal of the compensability decision. Id. at 50. In Dale E. Holden, 45 Van Natta 354 (1993), we extended our holding in Rocha to apply to stay the payment of permanent disability compensation.

We recognize the insurer's quandary that there is no statutory obligation to close a nondisabling claim. Webb v. SAIF, 83 Or App 386 (1987). However, the claim is deemed disabling until and unless it is finally determined nondisabling. See Georgia-Pacific v. Piwowar, 305 Or 494, 503-504 (1988); Georgia-Pacific v. Hughes, 305 Or 286, 293 (1988)(former ORS 656.313 required that compensation retain its identity as such pending appeal). Moreover, if an insurer is required to process a claim pending resolution of the underlying compensability issue, then it should also be required to continue its claim processing obligations on an accepted claim pending the resolution of the reclassification issue. We, therefore, agree with the Referee that the insurer's processing obligations are not affected by amended ORS 656.313.

In sum, final resolution of the reclassification issue does not interrupt the insurer's obligation to otherwise process its accepted claim. However, any compensation awarded pursuant to claim closure will be stayed until and unless the claim is otherwise found nondisabling. See Rocha, supra. Therefore, we agree with the Referee's conclusion that the Notice of Refusal to Close should be set aside and that the claim should be processed to closure.

Penalties and Attorney Fees

Finding that the "Notice of Refusal to Close" was unreasonable and constituted an unreasonable resistance to the payment of compensation, the Referee awarded a 25 percent penalty, under ORS 656.268(4)(f), based on all compensation due at claim closure and a $2,500 penalty-related attorney fee under ORS 656.382(1). We affirm and adopt the Referee's conclusions and reasoning regarding the penalty and attorney fee issue, with the following supplementation.

The insurer contends that the Referee's penalty award potentially creates a "double penalty" since Referee Nichols also assessed a penalty based on any subsequent award of permanent disability granted upon closure, for unreasonably classifying the claim as nondisabling.

There is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. See Robert A. Brooks, Jr., 44 Van Natta 1105 (1992). However, that is not the effect of the current Referee's order. The penalties were assessed in separate proceedings and pursuant to separate statutory provisions. Referee Nichols assessed a penalty and attorney fee pursuant to ORS 656.262(10) for unreasonable acceptance of the claim as nondisabling. Referee Johnson found that the insurer unreasonably refused to close the claim, warranting a penalty under ORS 656.268(4)(f) and an attorney fee under ORS 656.382(1). Referee Johnson did not err.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer'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 claim processing issue is $1,000, 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 and statement of services), the complexity of the issue, and the value of the interest involved. We further find that 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 August 7, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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Cite as 314 Or 633 (1992) November 25, 1992

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Betty S. Tee, Claimant.

BETTY S. **TEE**, Petitioner on Review,
v.
**ALBERTSONS, INC.**, Self Insured Employer, Respondent on Review.
(WCB 88-11538; CA A64558; SC S38437)

In Banc
On review from the Court of Appeals.*
Argued and submitted January 14, 1992.
Kevin N. Keaney, of Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, argued the cause for petitioner on review and filed the petition for review.
Thomas M. Christ, Portland, argued the cause for respondent on review and filed the response to the petition.
Donald M. Hooton, Eugene, filed an amicus curiae brief on behalf of Oregon Trial Lawyers Association.
PETERSON, J.
The decision of the Court of Appeals is modified, and the case is remanded to the Workers' Compensation Board for further consideration.
Graber, J., filed a dissenting opinion.
*Judicial review from the Workers' Compensation Board. 107 Or App 638, 813 P2d 574 (1991).

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**314 Or 635>** Here, an injured worker has been found capable of part-time work in an occupation, but her earnings would be approximately one-third of her pre-injury wages. She claims that her earnings are so greatly reduced as to entitle her to a permanent total disability (PTD) award. ORS 656.206(1)(a) provides:

> "'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

Claimant contends that the occupation that she has been found capable of performing part-time does not constitute a "gainful" occupation. She asserts:

> "The maximum earnings claimant could make post-injury without training is less than one-third of what she earned pre-injury. * * * [T]his disparity between pre-injury and post-injury salary establishes that the jobs which the Board found claimant could perform, as a matter of law, do not constitute gainful employment."[1]

Claimant, while working as a meat wrapper, suffered a back injury. Thereafter, claimant's back condition worsened, and she underwent a lumbar laminectomy and disectomy, left L4-5 and L5-S1 with an L4 through sacrum fusion. Claimant achieved a good result and returned to work in April 1981 without significant problems. In October 1984, while working for Albertson's, Inc. (employer), a self-insured employer, claimant slipped and almost fell, causing low back and bilateral leg symptoms. Claimant was off work for a brief period of time and then returned to work for three months, but was unable to continue. Claimant has not worked since mid-March 1985.

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[1] Claimant does not assert, as an independent ground for reversal, that her inability to work full-time entitles her to a PTD award.

Before her October 1984 injury, claimant worked a 40-hour week at an hourly rate of pay of $10.90. Her gross <314 Or 635/636> weekly pay was $436. The record contains evidence that telemarketing and hotel/motel inspector jobs pay $4.75 and $4.00 per hour, respectively, and that claimant could earn from $80 to $142.50 per week for such part-time work. As a part-time hotel/motel inspector or telemarketer, claimant's earnings would be as little as 18.3 percent of her pre-injury weekly wage (20 hours work at $4 per hour), but no more than 32.7 percent of her pre-injury weekly wage (30 hours at $4.75 per hour).

The referee concluded that claimant was not capable of regularly performing work at a gainful and suitable occupation and thus was entitled to PTD benefits. The Workers' Compensation Board (Board) reversed that part of the referee's order, concluding that claimant was "employable without training as a telemarketer and hotel/motel inspector" and that such work was available. Claimant does not contest that finding. The Board concluded that claimant was entitled to an award of 75 percent unscheduled permanent partial disability. The Court of Appeals, with one judge dissenting, affirmed. *Tee v. Albertsons, Inc.*, 107 Or App 638, 813 P2d 574 (1991). We modify the decision of the Court of Appeals and remand the case to the Board.

ORS 656.206(1) defines PTD as a loss "which permanently incapacitates the worker from regularly performing work at a *gainful* and *suitable* occupation." (Emphasis added.) The word "occupation" is modified by both "gainful" and "suitable." The term "suitable occupation" is defined in ORS 656.206(1)(a) as "one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation." The term "gainful occupation" is not defined by statute or rule. The decision in this case turns on the meaning of the term "gainful occupation" contained in the definition of PTD in ORS 656.206(1)(a) of the Workers' Compensation Law.

Before 1987, workers' compensation appeals to the Court of Appeals were *de novo*. ORS 656.298(6) (1985). In 1987, the legislature amended ORS 656.298(6) to provide: "Review shall be as provided in ORS 183.482(7) and (8)." Or Laws 1987, ch 884, 12a. Appeals to the Court of Appeals and <314 Or 636/637> this court are no longer *de novo*; reviews are under the Administrative Procedures Act, ORS 183.482.[2]

In ascertaining the meaning of "gainful occupation," we follow the methodology summarized in *Springfield Education Assn. v. School District*, 290 Or 217, 223-30, 621 P2d 547 (1980). In *Springfield*, this court discussed the allocation between administrative agencies and courts of responsibility for giving specific meaning to statutory terms. *Id.* at 221-30. The opinion divided statutory terms into three classes, each of which conveys to the agency different responsibilities for definition. The first class,

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[2] ORS 183.482(7) and (8) provide:

"Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. In the case of disputed allegations of irregularities in procedure before the agency not shown in the record which, if proved, would warrant reversal or remand, the Court of Appeals may refer the allegations to a Master appointed by the court to take evidence and make findings of fact upon them. The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

terms of precise meaning, requires the agency only to apply the terms to the facts. The second class, inexact terms, comprises a complete expression of legislative policy and requires the agency to interpret the legislature's meaning, either by rule or by a decision in a contested case. The third class, terms of delegation, is incomplete legislation that the agency is authorized to complete, by <314 Or 637/638> making rules within the range of discretion established by the statutes. *Id.* at 223.

The term "gainful occupation" in ORS 656.206(1)(a) is a statutory term within the second class described in *Springfield*. That is, it is a statutory term that embodies a complete expression of legislative meaning, even though its exact meaning is not necessarily obvious. To determine the intended meaning of an inexact statutory term, this court "look[s] to extrinsic indicators such as the context of the statutory term, legislative history, a cornucopia of rules of construction, and [its] own intuitive sense of the meaning which legislators probably intended to communicate by use of the particular word or phrase." *Id.* at 224. The ultimate inquiry is what the legislature intended by using the term. *Ibid.* The determination of the meaning of a statutory term is one of law, ultimately for the court. *Ibid.* Thus, the inquiry in this case is: What did the legislature intend by using the word "gainful" in ORS 656.206(1)(a)?[3]

Claimant makes several arguments in support of her contention that a "gainful" occupation, ORS 656.206(1)(a), is one that pays a wage comparable to the worker's pre-injury wage. First, she contends that the court, in interpreting the word "gainful," as used in ORS 656.206(1)(a), should adopt the statutory definition of "suitable employment" found in ORS 656.340(6)(b)(B)(iii), a definition that is used to determine whether an injured worker is entitled to vocational assistance,[4] and that incorporates comparability of pre-injury and post-injury wages. Under ORS 656.340, an injured worker who is not able to obtain "suitable employment" may be entitled to vocational assistance, at the expense of the insurer or self-insured employer, to enable the worker to achieve "a wage as close as possible to the worker's wage at the time of injury." ORS 656.340(5).[5] "Suitable <314 Or 638/639> employment" is defined, in part, as "[e]mployment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment." ORS 656.340(6)(b)(B)(iii). Claimant argues that that definition of what constitutes "suitable" employment should apply in the determination of PTD.

The major flaw in claimant's argument is that the definition of "suitable employment" on which she relies is limited to the statute containing the definition. ORS 656.340(6)(b)(B) provides: "As used in this subsection[,] * * * '[s]uitable employment' means * * *." That definition is not applicable to the determination of eligibility for PTD benefits. The PTD statute, ORS 656.206(1)(a), contains its own definition of "suitable occupation." As already noted, that definition provides that, "[a]s used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation." ORS 656.206(1)(a). Comparability to pre-injury wages is not part of that definition. Claimant wants "suitable" to mean "suitable" and "gainful" to mean "suitable." By using the word "gainful" in ORS 656.206(1)(a), the legislature signaled its intention that "gainful occupation" means something different from "suitable occupation," the difference being that a "gainful occupation" is an occupation for profitable remuneration. There is nothing to suggest that the definition of "suitable employment" in ORS 656.340(6)(b)(B) applies to a determination of PTD or in any context other than a determination under subsection (6) of ORS 656.340. ORS 656.340(6)(b)(B) provides no basis for adopting the definition proposed by claimant.

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[3] In construing a statute, the task of this court is to discern the intent of the legislature. ORS 174.010; *Mattiza v. Foster*, 311 Or 1, 4, 803 P2d 723 (1991). Neither party has discussed any legislative history of ORS 656.206(1). We reviewed the legislative history to see whether it contains anything concerning the meaning of "gainful," as used in ORS 656.206(2). It does not.

[4] There is no issue in the present case concerning whether claimant is entitled to vocational assistance.

[5] The right to vocational assistance is limited by ORS 656.340(14)(b), which provides:

> "Training shall not be provided to an eligible worker solely because the worker cannot obtain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage significantly closer to that prescribed in subsection (6) of this section."

Claimant next argues that the court should interpret the term "gainful" (which is not defined in ORS 656.206 or elsewhere) as the equivalent of "suitable" as defined in ORS 656.340(6)(b)(B)(iii). Claimant contends that not requiring comparability of wages for purposes of ORS 656.206(1)(a) is **<314 Or 639/640>** contrary to the purposes for which the Workers' Compensation Law was enacted. Claimant asserts that denying her PTD benefits because she is capable of regular part-time, low-paying employment is not consistent with the objective of returning "the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c).

There are two flaws in that argument. One is that it gives no weight to the significant difference between the specific goal of vocational assistance -- which is to "return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury," ORS 656.340(5) -- and the broader goal of the Workers' Compensation Law -- which is "[t]o restore the injured worker physically and economically to a self-sufficient status," ORS 656.012(2)(c). Second, claimant's argument discounts the different roles played by the PTD benefits statute and the vocational assistance statute and virtually ignores the existence and role of the statute providing for permanent partial disability (PPD) benefits, ORS 656.214, in achieving the declared objectives of the Workers' Compensation Law.

An award of PTD or PPD benefits aims to compensate an injured worker for permanently lost earning capacity, thereby promoting the goal of returning the worker to economic self-sufficiency. An injured worker who is incapable of regularly working at a gainful and suitable occupation is entitled to PTD benefits. ORS 656.206(1)(a). An injured worker who is not permanently totally disabled, but suffers from an unscheduled PPD,[6] is entitled to compensation for that proportion of earning capacity permanently lost as a result of a compensable injury. ORS 656.214(5). PPD benefits aim to compensate the worker who is capable of regular work, but whose earning capacity has been diminished permanently as a result of injury.[7]

**314 Or 641>** Vocational assistance, on the other hand, aims to ameliorate lost earning capacity by retraining. It promotes the general goal of self-sufficiency by assisting permanently disabled workers to achieve wages comparable to their pre-injury wages. ORS 656.340(6) and (14). If vocational assistance is successful, the injured worker's status may be re-evaluated to allow for a reduction in the extent or for the complete elimination of permanent disability benefits. See ORS 656.206(5) (requiring insurers to re-examine PTD claims every two years); ORS 656.325(3) (awards of PTD and unscheduled PPD benefits shall be subject to periodic examination and adjustment). Because vocational assistance serves a different purpose than that served by PTD and PPD benefits, there is no sound reason for interpreting the term "gainful" in ORS 656.206(1)(a) as equivalent to "suitable" as defined in ORS 656.340(6)(b)(B)(iii).

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[6] ORS 656.214(1)(b) defines PPD. ORS 656.214(2) to (4) set forth a schedule for determining the amount of compensation that a claimant is entitled to receive for the permanent loss of use or function of various body parts. ORS 656.214(5) sets forth the method for determining compensation for a compensable injury resulting in an unscheduled PPD.

[7] Claimant also relies on a 1983 decision of the Court of Appeals that interpreted "gainful employment" for purposes of determining eligibility for vocational rehabilitation under ORS 656.340 (1983). *Frame v. Crown Zellerbach*, 63 Or App 827, 665 P2d 879, former *opinion adhered to*, 65 Or App 801, 672 P2d 70 (1983). At that time, ORS 656.340 (1983) provided for vocational assistance to be provided in accordance with administrative rules. The inability of a worker to return to "gainful employment" qualified the worker for vocational assistance. The Court of Appeals concluded:

> "Gainful employment, in the light of the intent of the workers' compensation statutes (and the regulations of the Department), must bear a reasonable relationship to an individual's experience and background, including prior earnings." 63 Or App at 831.

In 1987, the legislature amended ORS 656.340 to set forth the eligibility criteria within the statute, including the definition of what constitutes suitable employment for purposes of determining eligibility. Or Laws 1987, ch 884, 15. Claimant argues that the legislature's incorporation of the *Frame* court's wage comparability element into the statutory definition of "suitable employment" amounts to a legislative adoption of the reasoning and conclusions made by the *Frame* court. Whether or not that is true, it is beside the point. The present case concerns the right of an injured worker to PTD benefits, not to vocational assistance.

Claimant relies on *Harris v. SAIF*, 292 Or 683, 642 P2d 1147 (1982), which also concerned eligibility for PTD benefits. There, the court determined that an injured worker who earned substantial income on real estate investments still could be entitled to PTD benefits, because the criterion for PTD is not income, but employability. 292 Or at 694-95. The court stated the test as follcws:

> "The determination of [PTD] status does not turn upon whether the claimant has money-earning capacity, but rather upon whether the claimant is currently employable or **<314 Or 641/642>** able to sell his services on a regular basis in a hypothetically normal labor market." *Id.* at 695.

The claimant's active, albeit irregular, participation in his real estate investment activities, and his ability thereby to earn income did not mean that he was no longer permanently totally disabled.[8] *Id.* at 695-96. The *Harris* court remanded the case to the Board for a determination of the claimant's employability at some occupation. *Id.* at 697. *Harris* does not apply here, because the question that claimant raises is not whether claimant is *employable* (which was the issue in *Harris*), but rather whether the occupation that she is deemed capable of performing is *gainful*.

Requiring post-injury employment to produce a wage comparable to a worker's pre-injury wage, in order to be "gainful," would judicially overrule, at least in part, the statutory provision for unscheduled PPD. According to claimant's argument, any worker with a permanent disability who is not capable of post-injury employment that would produce 80 percent of the wages paid for the worker's pre-injury employment would be entitled to PTD benefits. PPD benefits thus would be limited to workers whose earning capacity was diminished less than 20 percent as a result of an unscheduled permanent disability. There is nothing in the PPD statute that indicates that it is so limited. The legislature has created a system that compensates unscheduled PPD on the basis of its permanent effect on earning capacity. The decision to compensate injured workers for unscheduled PPD reflects a **<314 Or 642/643>** policy choice that such workers should be required to earn that portion of their income that they are capable of earning in regular employment. PPD benefits are for injured workers who are permanently *partially* disabled.

Having rejected claimant's contentions concerning the meaning of "gainful occupation," our "ultimate task [is] to discern and apply the legislature's intended meaning." *Springfield Education Assn. v. School District, supra*, 290 Or at 217. As stated, ORS 656.206(1)(a) itself defines a "suitable occupation" as "one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation." The definition of "suitable occupation" concerns work that the worker is capable of performing, irrespective of the remuneration received for the work. What is the worker capable of doing? By contrast, the term "gainful occupation" concerns remuneration; it relates to the earnings that the worker can obtain by working at a "suitable occupation." The plain and ordinary meaning of "gainful" is "profitable, lucrative: *gainful employment.*" The Random House Dictionary of the English Language 782 (2d ed 1987) (emphasis in original). The term "gainful occupation" contained in the definition of PTD in ORS 656.206(1)(a) means profitable remuneration.

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[8] In discussing the test for PTD, the court in *Harris v. SAIF*, 292 Or 683, 695, 642 P2d 1147 (1982), quoted the following passage from 2 Larson, Workmen's Compensation Law 10-164.21 to 10-164.49, 57.51 (1976):

> "'Total disability' in compensation law is not to be interpreted literally as utter and abject helplessness. Evidence that claimant has been able to earn occasional wages or perform certain kinds of gainful work does not necessarily rule out a finding of total disability nor require that it be reduced to partial. The task is to phrase a rule delimiting the amount and character of work a man can be able to do without forfeiting his totally disabled status."

The quoted passage is not contrary to our discussion. ORS 656.206(1)(a) reflects the legislature's approach to the task of "phras[ing] a rule delimiting the amount and character of work a [person] can be able to do without forfeiting his [or her] totally disabled status." *Ibid.* The statute addresses Larson's concerns by requiring that an injured worker be "permanently incapacitate[d] * * * from *regularly performing work at a gainful and suitable occupation*" (emphasis added), in order for the worker to be considered permanently totally disabled. Whether or not the statute completely satisfies the concerns posited by Larson, however, is not relevant to our task.

The Board found that "both the telemarketing job and the hotel/motel room inspectress jobs were gainful and suitable employments for claimant." It then "concluded that claimant is not permanently and totally disabled" and awarded claimant an unscheduled permanent disability of 75 percent. The Board did not have the benefit of this opinion in deciding whether claimant's part-time employment was for profitable remuneration. Its decision was not made in light of the meaning of "gainful occupation" contained in this opinion. Because this is the first decision of this court interpreting the meaning of "gainful occupation," and because the Board is the appropriate body to apply the meaning of "gainful occupation" under the facts of this case in performing its fact-finding function, it is appropriate to remand this case to the Board for further consideration in light of this opinion.[9]

**314 Or 644>** Therefore, the decision of the Court of Appeals is modified, and this case is remanded to the Workers' Compensation Board for further consideration.

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[9] Claimant also contends that the Board did not make "a specific and express finding" that claimant "is presently able to regularly perform a gainful and suitable occupation." In light of our disposition, we need not address this issue.

**GRABER, J., dissenting.**

I concur in the majority's opinion, with one key exception. The majority defines "gainful occupation" in ORS 656.206(1)(a) to mean work for "profitable remuneration." 314 Or at 643. The adjective "profitable" is, in my view, unnecessary, ambiguous, and potentially misleading.

A "gainful occupation" within the meaning of the statute defining permanent total disability is simply an occupation for which the worker receives a lawful wage. By contrast, if one's only suitable occupation is as an unpaid volunteer, an upaid homemaker, or the like, one's occupation is not "gainful." It matters not -- for the purpose of ORS 656.206(1)(a) -- whether the worker's remuneration results in a "profit." For example, a worker who is capable of owning a print-shop that is expected to gross $50,000 per year has a "gainful occupation" even if the business happens to lose money one year, and a worker who is employable at a suitable minimum-wage job has a "gainful occupation" even if expenses make it difficult to make ends meet. The statute is intended only to define a status of permanent total disability, nothing more.

Because I would not add the undefined concept of "profitable" to the definition of PTD, I would affirm, rather than returning this case to the Workers' Compensation Board. Accordingly, I dissent.

Cite as 314 Or 719 (1992) December 4, 1992

IN THE SUPREME COURT OF THE STATE OF OREGON

CHARLES B. **GILL**, JR., and DAVID A. DAVIDSON,
v.
**STATE ACCIDENT INSURANCE FUND CORPORATION**, HERBERT ASCHKENASY, DONALD COOK, HARRIET SHERBURNE, THOMAS SPITZER and DANIEL WILLIAMS,
(CC 89C12469; CA A65889; SC S38998)

In Banc
On review from the Court of Appeals.*
Argued and submitted September 2, 1992.
Bruce A. Rubin, Portland, argued the cause for petitioners on review. With him on the petition were William B. Crow and Carolyn E. Wells, of Miller, Nash, Weiner, Hager & Carlsen, Portland.
William F. Gary, Special Assistant Attorney General, Eugene, argued the cause for respondents on review. With him on the response were Sharon A. Rudnick, Special Assistant Attorney General, and Harrang, Long, Watkinson, Arnold & Laird, P.C., Eugene, and Charles S. Crookham, Attorney General, Jack L. Landau, Deputy Attorney General, and Virginia L. Linder, Solicitor General, Salem.
VAN HOOMISSEN, J.
The decision of the Court of Appeals on appeal is affirmed as modified with respect to the remand. The decision of the Court of Appeals on cross-appeal is affirmed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for entry of a judgment for defendants.
Peterson, J., concurred and filed an opinion.

*Appeal from Marion County Circuit Court, Albin W. Norblad, Judge, 110 Or App 533, 823 P2d 447 (1992).

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**314 Or 721>** This is a claim for indemnity under ORS 30.285.[1] Plaintiffs Gill and Davidson (plaintiffs) seek indemnity from defendants, the State Accident Insurance Fund Corporation (SAIF) and its current and former directors, for attorney fees and costs that plaintiffs incurred in defending themselves in the case of *SAIF v. Montgomery*, which was filed in Marion County Circuit Court in 1984.[2] The narrow issue presented on review is whether the Court of Appeals correctly concluded that proof of actual loss is required for indemnity under ORS 30.285(1). The broader issue presented, however, is whether the indemnity provisions of ORS 30.285(1) apply at all under the circumstances of this case.

The trial court decided the case on the both the narrow and broader issues, concluding that the state was obligated to indemnify plaintiffs and that proof of actual loss was not necessary for indemnity under ORS 30.285(1).[3]

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[1] ORS 30.285 provides in part:

"(1) The governing body of any public body shall defend, save harmless and indemnify any of its officers, employees and agents, whether elective or appointive, against any tort claim or demand, whether groundless or otherwise, arising out of an alleged act or omission occurring in the performance of duty.

"(2) The provisions of subsection (1) of this section do not apply in case of malfeasance in office or willful or wanton neglect of duty."

[2] In *SAIF v. Montgomery*, SAIF sued plaintiffs in this case and others to recover damages for misallocation of money and lost corporate opportunities that allegedly resulted from the negotiation and performance of contracts between SAIF and the Association of Oregon Loggers. *See SAIF v. Montgomery*, 108 Or App 93, 814 P2d 536, *rev den* 312 Or 589 (1991) (explaining case history).

[3] Plaintiffs presented no evidence that they, in fact, had any actual loss for attorney fees or costs. At trial, a witness testified that plaintiffs' defense costs had been paid by their current employer. There was no evidence that plaintiffs have any responsibility to repay or to seek reimbursement for their present employer.

The Court of Appeals decided the case only on the narrow issue, concluding that proof of actual loss is required for indemnity under ORS 30.285(1), and reversed and remanded the case to the trial court to consider whether plaintiffs had suffered any actual loss. *Gill v. SAIF*, 110 Or App 533, 536, 823 P2d 447 (1992). The court specifically did not address the broader issue whether plaintiffs' claims are cognizable under ORS 30.285(1). *Id.* at 537 n 3. We agree with the Court of Appeals that proof of actual loss is required for **<314 Or 721/722>** indemnity under ORS 30.285(1). For the reason that follows, however, we disagree with the Court of Appeals' reason for remanding this case to the trial court.

Plaintiffs Gill and Davidson formerly were employed by SAIF as president and vice president, respectively. SAIF brought an action against them, claiming that they had breached their fiduciary duties and that they were strictly accountable for a resulting loss of public funds. ORS 297.120 (1989).[4] That underlying action is discussed more fully in *SAIF v. Montgomery*, 108 Or App 93, 814 P2d 536, *rev den* 312 Or 589 (1991). Plaintiffs tendered their defense of *SAIF v. Montgomery* to the Attorney General, who rejected the tender. ORS 30.285(3).[5] Plaintiffs then retained private **<314 Or 722/723>** counsel. The trial court later granted plaintiffs' motion for partial summary judgment on the issue of liability, and entered judgment in their favor.

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[4] ORS 297.120 (1989) provided:

"(1) When a state agency sustains a loss of public funds or property under circumstances involving a public officer who is entrusted with the custody of the funds or property or who is charged with the duty to account for the funds or property, the Division of Audits shall investigate the loss and prepare a report respecting the accountability of the public officer for the loss. The report shall be presented to the Governor.

"(2) The Governor shall review the report presented pursuant to subsection (1) of this section, and if the Governor concurs with a determination of accountability contained in the report, the Governor shall direct the appropriate state agency to, and the agency shall, seek to recover the loss from the public officer, the surety of the public officer and other responsible parties; provided, however, that the Governor may direct that no action be taken to recover the loss from the public officer and the surety of the public officer if the Governor determines that the officer is free from personal fault and that the loss was not caused by the dishonest act, wrongful conduct, negligence or carelessness of the public officer."

[5] ORS 30.285 provides in part:

"(3) If any civil action, suit or proceeding is brought against any state officer, employee or agent which on its face falls within the provisions of subsection (1) of this section, or which the state officer, employee or agent asserts to be based in fact upon an alleged act or omission in the performance of duty, the state officer, employee or agent may, after consulting with the Department of General Services file a written request for counsel with the Attorney General. The Attorney General shall thereupon appear and defend the officer, employee or agent unless after investigation the Attorney General finds that the claim or demand does not arise out of an alleged act or omission occurring in the performance of duty, or that the act or omission complained of amounted to malfeasance in office or willful or wanton neglect of duty, in which case the Attorney General shall reject defense of the claim."

The Attorney General based his rejection of plaintiffs' defense on his conclusions that ORS 30.285 does not apply to actions brought by the state under ORS 297.120(2) (1989) and that, in any case, Gill and Davidson would be disqualified under the provisions of ORS 30.285(2), which provides that ORS 30.285(1) does not apply "in case of malfeasance in office or willful or wanton neglect of duty."

After the trial court's judgment was entered in *SAIF v. Montgomery*, but before that case was concluded on appeal, plaintiffs brought this action against defendants. ORS 30.285(5).[6] Both parties moved for summary judgment on the issue whether the indemnity provisions of ORS 30.285 apply when an action is brought by the state against its own employees, but the employees later are exonerated.[7] The trial court granted partial summary judgment for plaintiffs, holding that, because the claims against plaintiffs in *SAIF v. Montgomery* were torts, the indemnity provisions of ORS 30.285 applied.[8]

Defendants appealed to the Court of Appeals on numerous issues, including whether the indemnity provisions of ORS 30.285 apply when an action is brought by the state against its own employees, but the employees later are exonerated, and whether proof of actual loss is necessary for indemnity under ORS 30.285.[9] The Court of Appeals **<314 Or 723/724>** reversed, holding that proof of actual loss is required for indemnity under ORS 30.285, citing *Aetna Casualty & Surety Co. v. OHSU*, 310 Or 61, 793 P2d 320 (1990). Because the Court of Appeals disposed of defendants' appeal on that ground, it did not address the question whether the indemnity provisions of ORS 30.285 apply at all on these facts. *Gill v. SAIF, supra*, 110 Or App at 537 n 3. Plaintiffs petitioned for review in this court.

We address the narrow issue of whether proof of actual loss is required for indemnity under ORS 30.285. Plaintiffs argue that they need not prove that they actually spent anything, but only that they initially incurred liability for their attorney fees and costs.

Assuming, *arguendo*, that plaintiffs are entitled to indemnity under ORS 30.285, a question we specifically do not decide in this case,[10] we hold that they still may not prevail, because they have suffered no actual loss. *See Aetna Casualty & Surety Co. v. OHSU, supra*, 310 Or at 64-65 (no indemnity is due under ORS 30.285 in the absence of actual loss).

On summary judgment, plaintiffs presented no evidence that they expended any money of their own to defend themselves in SAIF v. Montgomery, nor did they present evidence that they were obligated to repay or to seek reimbursement for their present employer, who did pay their attorneys' fees and costs.

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[6] ORS 30.285 provides in part:

> "(5) If the Attorney General rejects defense of a claim under subsection (3) of this section or this subsection, no public funds shall be paid in settlement of said claim or in payment of any judgment against such officer, employee or agent. Such action by the Attorney General shall not prejudice the right of the officer, employee or agent to assert and establish an [sic] appropriate proceedings that the claim or demand in fact arose out of an alleged act or omission occurring in the performance of duty, or that the act or omission complained of did not amount to malfeasance in office or willful or wanton neglect of duty, in which case the officer, employee or agent shall be indemnified against liability and reasonable costs of defending the claim * * *."

[7] Plaintiffs' claim for indemnity assumes that SAIF is a "public body" within the meaning of the Oregon Tort Claims Act (OTCA). *Cf. Frohnmayer v. SAIF*, 294 Or 570, 582, 660 P2d 1061 (1983) (SAIF is subject to Attorney General's ORS chapter 180 authority).

[8] The issue of plaintiffs' attorney fees and costs was tried to the court. Evidence showed that plaintiffs were billed $173,355.07 by their attorneys. The trial court held that the state was obligated to indemnify plaintiffs, because they had incurred the liability and had seen that the obligation was paid. The court explained that "to rule otherwise would be to unjustly enrich SAIF simply because the actual checks were not written by Gill or Davidson."

[9] Plaintiffs cross-appealed, arguing that the trial court abused its discretion in refusing to allow them to amend their complaint shortly before trial. The Court of Appeals affirmed on the cross-appeal. Because the proposed amendment would not have cured the defect identified in the text of this opinion, we likewise affirm on the cross-appeal.

[10] The legislative history of the OTCA does not indicate that the legislature considered whether the indemnity provisions of ORS 30.285 would apply to actions brought by the state against its employees, whether or not the employees later were exonerated.

ORS 30.285(1) provides:

> "The governing body of any public body shall defend, save harmless and indemnify any of its officers, employees and agents, whether elective or appointive, against *any* tort claim or demand, whether groundless or otherwise, arising out of an alleged act or omission occurring in the performance of duty." (Emphasis added.)

The legislature enacted that sweepingly worded section to eliminate the concern of public employees that they could be held personally liable for a failure to use reasonable care in **<314 Or 724/725>** performing their jobs and thereby to encourage able persons to accept responsible employment in the public sector. *Stevenson v. State of Oregon*, 290 Or 3, 12-13, 619 P2d 247 (1980). Indemnification for actual out-of-pocket losses completely fulfills that legislative purpose. To require a public body also to pay for someone else's loss, however, would be to permit a windfall to a public employee. Nothing in the Oregon Tort Claims Act or in its history suggests that result. Accordingly, we hold that proof of actual loss is required for indemnity under ORS 30.285(1). Plaintiffs here have not proved any actual loss to themselves. They therefore are not eligible for indemnity under ORS 30.285(1).

The Court of Appeals reversed and remanded this case for further findings of fact on whether plaintiffs have suffered any actual loss. *Gill v. SAIF, supra*, 110 Or App at 536. The record appears to be complete on that point, however, and to show that plaintiffs had suffered no actual loss. For that reason, we disagree with the Court of Appeals' reason for remanding this case to the trial court. We conclude that a remand to the trial court for entry of a judgment for defendants is proper.

The decision of the Court of Appeals on appeal is affirmed as modified with respect to the remand. The decision of the Court of Appeals on cross-appeal is affirmed. The judgment of the circuit court is reversed. The case is remanded to the circuit court for entry of a judgment for defendants.

PETERSON, J., concurring.

I join in the opinion of the court, but write separately to raise a point for possible attention by the Legislative Assembly.

According to the court's opinion, "[t]he broader issue * * * is whether the indemnity provisions of ORS 30.285(1) apply at all under the circumstances of this case." 314 Or at 721. That issue is not decided by the opinion in this case.

The Oregon Tort Claims Act defines "tort" broadly. ORS 30.260(8) provides:

> **314 Or 726>** "'Tort' means the breach of a legal duty that is imposed by law, other than a duty arising from contract or quasi-contract, the breach of which results in injury to a *specific person* or persons for which the law provides a civil right of action for damages or for a protective remedy." (Emphasis added.)

The Legislative Assembly would be well advised to consider whether the words "specific person," as used in ORS 30.260(8), include the state and its agencies, and whether it intends that state employees in the position of plaintiffs herein, responding to claims made against them by the state or an agency of the state, are entitled to indemnity under ORS 30.285.

Cite as 116 Or App 537 (1992) November 25, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Randolph A. Krieger, Claimant.

RANDOLPH A. **KRIEGER**, Petitioner,
v.
**FUTURE LOGGING** and SAIF CORPORATION, Respondents.
(WCB 89-03927; CA A71330)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 12, 1992.
David C. Force, Salem, argued the cause for petitioner. With him on the brief was Vick & Gutzler, Salem.
Steven Cotton, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

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**116 Or App 539>** Claimant seeks review of an order of the Workers' Compensation Board holding that, by entering into a disputed claim settlement (DCS) pursuant to ORS 656.289(4),[1] claimant settled his claim for neck surgery and that, by entering into a claim disposition agreement (CDA) pursuant to ORS 656.236(1), he settled his aggravation claim. We affirm the Board and write only to discuss the scope of the DCS and whether recent statutory amendments permitting CDA's are applicable to the aggravation claim.

Claimant compensably injured his head, left wrist and shoulder and cervical spine in August, 1987. In April, 1989, Dr. Melgard requested permission for surgery for decompression and stabilization at C6-C7. In October, 1989, SAIF denied the request for surgery and also denied an aggravation claim. A referee found the surgery to be compensable but affirmed SAIF's denial of the aggravation claim. Claimant appealed to the Board.

SAIF continued to dispute the compensability of the surgery. Melgard submitted a second request for surgery for the same neck condition, and SAIF denied it in February, 1990. On October 30, 1990, a referee approved a DCS resolving claimant's "alleged entitlement to additional compensation for surgery to his neck." In November, 1990, the Board approved a separate CDA relating to "compensation and payments of any kind due or claimed for the past, present, and the future, except compensable medical services."

After the CDA and the DCS were approved, the Board issued an order on the first request for surgery and the aggravation claim, holding them compensable. On reconsideration, the Board concluded that the compensability of the surgery, encompassing the denials of October, 1989, and February, 1990, had been settled by the DCS and that the aggravation claim had been settled by the CDA; the Board vacated the portions of its order setting aside the denials.

**116 Or App 540>** The Board correctly concluded that the DCS settled the compensability of the surgery in its entirety. Although the DCS itself made express reference only to the February, 1990, denial, the subject of the DCS was the same surgery that had been requested and denied in October, 1989. We conclude that the DCS resolved both surgery requests and denials.

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[1] That subsection provides:

"Notwithstanding ORS 656.236, in any case in which there is a bona fide dispute over the compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable."

The Board also correctly held that the CDA settled the aggravation claim, which had also been denied in October, 1989. The CDA provided:

> "Pursuant to ORS 656.236, the parties have agreed to settle Claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services * * *. 'Compensation and payments of any kind due or claimed' includes temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services.
>
> "Additionally, all pending requests for hearing, if any, shall be dismissed with prejudice, as to all issues raised or raisable at this time."

We conclude that the Board held correctly that the CDA resolved "any and all" claims arising from claimant's August, 1987, injury, including claimant's aggravation claim.

Until 1990, ORS 656.236(1) provided that "[n]o release by a worker or beneficiary of any rights under ORS 656.001 to 656.794 is valid." Oregon Laws 1990 (Special Session), chapter 2, section 9, amended ORS 656.236(1) to permit a claimant to release rights on an accepted claim by way of a CDA. The statute now provides, in part:

> "The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the director may prescribe."

Claimant contends that the CDA does not bind him, because the amended version of ORS 656.236(1) is inapplicable to his claim. Oregon Laws 1990 (Special Session), chapter 2, section 54, provides, in pertinent part:

> **116 Or App 541>** "(1) Except for amendments to ORS 656.027, 656.211, 656.214(2) and 656.790, this Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing on or after July 1, 1990, regardless of date of injury, except as specifically provided in this section.
>
> "(2) 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."

Because the hearing in this matter was requested before May 1, 1990, and convened before July 1, 1990, claimant is correct that, pursuant to section 54(2), the law in effect before July 1, 1990, would have governed the substantive aspects of his aggravation claim, had it been resolved through litigation. However, the amendments to ORS 656.236 permitting the settlement of a claim by CDA became operative on July 1, 1990. Or Laws 1990 (Spec Sess), ch 2, 54(1); *see SAIF v. Herron*, 114 Or App 64, 836 P2d 131 (1992). Accordingly, that procedural mechanism was available to claimant for the settlement of his aggravation claim in November, 1990, regardless of the fact that the claim was in litigation. Claimant released his rights by entering into the CDA, which the Board approved. The Board's order has the finality and effect of a judgment and is not subject to review in this proceeding. ORS 656.236(2).

Claimant's remaining arguments do not merit discussion.

Affirmed.

Cite as 116 Or App 635 (1992) December 2, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard L. Jasenosky, Claimant.

**IRVINGTON TRANSFER** and SAIF CORPORATION, Petitioners,
v.
RICHARD L. **JASENOSKY**, Respondent.
(90-01455; CA A69535)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 24, 1992.
Kenneth L. Kleinsmith, Portland, argued the cause for petitioners. With him on the brief was Meyers & Radler, Portland.
Glen H. Downs, Portland, argued the cause for respondent. With him on the brief were J. Michael Casey and Doblie & Associates, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.

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**116 Or App 637>** Employer seeks review of a Worker's Compensation Board order that held that claimant's injury, which resulted from an altercation with a fellow employee at work, was not excluded from compensability under *former* ORS 656.005(7)(a) as an injury sustained by a claimant who was an "active participant" in a fight that occurred on the job.[1] Employer argues that the Board's findings are not supported by substantial evidence and that the Board erred as a matter of law in concluding that claimant was not an active participant in the altercation. We affirm.

Claimant was a furniture mover. In early December, 1989, he told employer that a co-worker, Cottingham, had verbally threatened him and that he did not want to work with Cottingham again. On December 20, 1989, claimant was assigned to work in the storage bay next to Cottingham. Shortly after claimant started working, another employee told him that "Cottingham still wants to kick your ass. That's all he talks about." As the referee found, after hearing that comment:

> "Claimant was angry and upset that Cottingham still wanted to fight. Within ten minutes of his assignment to bay 3, claimant left his area and approached the top of bay 2. He held cardboard in his left hand. When he was about 30 feet away from Cottingham, he yelled to him over the warehouse noise, 'What's the matter with you? Why do you want to kick my ass?'. Claimant made no gestures toward Cottingham when he said this; his hands were at his sides.
>
> "Cottingham looked at claimant and said, 'F___ you!' Claimant then turned to go back to work. Immediately, Cottingham charged out of bay 2 and grabbed claimant around the neck with both hands. Claimant hit Cottingham one time in the head with his fist and was able to break free. Once free from Cottingham's grasp, claimant ceased his attack. Cottingham grabbed for claimant's throat again, but claimant maneuvered Cottingham into a bearhug [sic] and headlock. * * * Finally, [two co-workers] pulled them apart, two or three feet inside bay 2. Claimant moved away from Cottingham to avoid any further altercation while **<116 Or App 637/638>** Cottingham had to be restrained by two men from returning to assault claimant.
>
> "When [a co-worker] pulled claimant from Cottingham, he stepped on claimant's ankle and broke it."

The referee concluded that claimant was involved in an assault that was not connected to the job assignment and which amounted to a deviation from his customary duties. The referee held, however,

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1 The statute has been renumbered ORS 656.005(7)(b)(A). Or Laws 1990, ch 2, 3.

that claimant was not an active participant in the altercation, because he did not verbally provoke Cottingham into fighting and did not physically initiate the attack or assault Cottingham during the fight. The Board affirmed, adopting the referee's factual findings and legal conclusions.

Employer first argues that the Board's findings that claimant did not verbally provoke the assault and acted only in self-defense are not supported by substantial evidence. Substantial evidence supports a finding when a reasonable person could make the same finding after reviewing the entire record. ORS 183.482(8)(c).

We conclude that the Board's findings are supported by substantial evidence. There is conflicting evidence of what happened between claimant and Cottingham. Ten witnesses testified, most offering somewhat different accounts of the event. However, the referee made credibility findings, which he explained in detail. He stated that he made his credibility determinations on the basis of witnesses' appearance, demeanor and attitude, as well as on the substance of their testimony. The referee completely discounted Cottingham's testimony, explaining that it included numerous inconsistencies and contradictions. The referee found that the testimony of claimant and one other witness, Moyer, was credible. Their testimony included evidence that claimant did not provoke Cottingham's assault and that he only acted in self-defense. Accordingly, there was substantial evidence in the record supporting the Board's findings.

Employer next argues that, even assuming the correctness of the Board's findings, it erred as a matter of law in its interpretation of the term "active participant" used in former ORS 656.005(7)(a):

> **116 Or App 639>** "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, 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. However, 'compensable injury' does not include:
>
> "(A) 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[.]"

In *Kessen v. Boise Cascade Corp.*, 71 Or App 545, 548, 693 P2d 52 (1984), we delineated a four-part test for determining when an injury is excluded from compensation because the claimant sustained an injury as an active participant in a fight:[2]

> "In order to be barred from receiving compensation, (1) the claimant must be an active participant, (2) in assaults or combats, (3) which must not be connected to the job assignment and (4) which must amount to a deviation from customary duties."

The parties do not dispute the Board's conclusions that the injury occurred during a fight that was unconnected to claimant's job assignment and was a deviation from his customary duties. Employer takes issue with the Board's conclusion that claimant was not an active participant in the fight.

Employer argues that we held in *Kessen v. Boise Cascade Corp., supra,* and *SAIF v. Barajas,* 107 Or App 73, 810 P2d 1316 (1991), that the exclusion in *former* ORS 656.005(7)(a) bars coverage for *any* employee who participates in *any* way in a fight, "not just those who provoke or initiate fights or who are the aggressors in fights." The holdings in those cases are not that broad. In *Barajas,* the claimant did not provoke or initiate the fight, but he was involved in the fight. We remanded the case, however, because there were "no findings as to how or why claimant became involved in an altercation with Gomez while Gomez was armed with a knife." *SAIF v. Barajas, supra,* 107 Or App at 77. The critical question in *Barajas* that was not resolved by the Board's findings was not whether the claimant was **<116 Or App 639/640>** involved in a fight; he was. Rather, it was whether he had voluntarily assumed an active or aggressive role in the fight. If the claimant there had had an opportunity to withdraw from the encounter and not participate in the fight and did not do that, he would have been an "active participant" under the statute. That was why it was necessary to remand the case for additional findings.

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2 *Kessen* was decided under *former* ORS 656.005(8)(a), which was substantially the same as the provision at issue in this case.

In *Kessen v. Boise Cascade Corp., supra*, we did not hold that a claimant need only be involved in a fight to be an "active participant" under the statute. We held that the claimant was an active participant in a fight, even though he received the only blow struck, because he "was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight." 71 Or App at 548.

Claimant here was returning to his assigned work area after asking his co-worker why he still wanted to "kick his ass," when his co-worker charged him and assaulted him. According to the Board's findings, claimant did not have an opportunity to withdraw from the situation and he did not voluntarily assume an active or aggressive role in the altercation. The Board did not err in concluding that claimant was not an active participant in the fight and that, accordingly, *former* ORS 656.005(7)(a) did not exclude claimant's injuries from compensability.

Affirmed.

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Cite as 116 Or App 671 (1992) December 2, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jimmie A. Childers, Claimant.

JIMMIE A. **CHILDERS**, Petitioner,
v.
**IRVINE TRUCKING** and SAIF CORPORATION, Respondents.
(89-23472; CA A70514)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 24, 1992.
Donald M. Hooton, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.
Steve Cotton, Special 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 Deits and Durham, Judges.
PER CURIAM
Review dismissed.

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**116 Or App 672>** Claimant seeks review of an order of the Workers' Compensation Board refusing to exercise its own motion jurisdiction to reopen his claim to allow time loss benefits and medical expenses. We dismiss the review.

Claimant was injured in 1961 and was awarded both scheduled and unscheduled permanent disability in a 1962 determination order. In 1989, he filed an aggravation claim. He also sought medical expenses for surgery that he contended related to his original injury. Because claimant's aggravation rights had expired and because his injury occurred before January 1, 1966, both claims had to be considered by the Board under its own motion jurisdiction. ORS 656.278(1). The Board recognized that but refused to exercise its own motion jurisdiction on either claim. Claimant now seeks review of the Board's order. Because the Board did not reduce or terminate claimant's former award, he has no right to have the order reviewed. ORS 656.278(3).

Review dismissed.

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Cite as 117 Or App 24 (1992) December 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert Brown, Claimant.

Robert **BROWN**, *Petitioner,*
v.
**NELSON INTERNATIONAL** and SAIF Corporation, *Respondents.*
(90-12237, 90-07211; CA A71414)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 13, 1992.
Charles Robinowitz, Portland, argued the cause and filed the brief for petitioner.
Julie K. Bolt, Special Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P. J.
Affirmed.

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**117 Or 26>** In October, 1985, claimant suffered a compensable injury. The Evaluation Division found him medically stationary on April 22, 1988, and awarded him 55% permanent partial disability. After a hearing on November 11, 1988, the referee increased the disability award to 80%. On review, the Board held that claimant is permanently totally disabled, effective November 11, 1988. Claimant did not petition for judicial review.

In June, 1990, claimant filed a request for a hearing, contending, *inter alia,* that he was owed temporary total disability benefits from April 22 to November 11, 1988, and that his permanent total disability benefits should be calculated using the same cost-of-living adjustments used to calculate his temporary total disability benefits. The Board adopted the referee's opinion, which denied the claims. We affirm.

Claimant first argues that he is entitled to benefits from April to November, 1988, because, once he was found to be permanently disabled, the effective date is "by definition" the medically stationary date. He characterizes the Board's award of PTD effective November 11 as the "law of the case" and contends that, by that ruling, the Board changed his medically stationary date. Therefore, he argues, he is entitled to temporary total disability benefits for April to November.

As authority, claimant relies on ORS 656.268(1) and (2). However, those sections provide that a claim may not be closed if a worker is not medically stationary or is "actively engaged" in training. Here, the Board held that its determination that November was the effective date was not "entirely inconsistent" because, at the time when the claim was ready for closure, claimant was receiving temporary benefits because he was participating in a vocational program, not because he was not medically stationary.

The Board then concluded that, regardless of the basis for the November date, claimant had waived the issues of premature closure and temporary disability benefits by not raising them at the November hearing and that, even if he had not, the time to challenge the effective date of the award of permanent total disability was when the Board issued its **<117 Or App 26/27>** order. We agree with that conclusion. Claimant did not seek reconsideration or judicial review of the Board's order; therefore, that order, including the determination of the date when claimant became permanently totally disabled, became final. ORS 656.295(8).

Claimant next argues that the Board erred in holding that the cost-of-living increases that applied to his temporary total disability benefits did not apply to the calculation of wages for permanent total disability. The cost-of-living adjustment for temporary benefits was calculated under ORS 656.210(1), which provides, in part:

> "Notwithstanding the limitation [on compensation] imposed by this subsection, an injured worker who is not otherwise eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have the benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year. "

He contends that that adjustment also applies to determine the wage rate for permanent total disability benefits under ORS 656.206, because "wages" for purposes of permanent total disability "means wages as determined under ORS 656.210." ORS 656.206(1)(b).

However, the cost-of-living adjustment under ORS 656.210(1) applies only to increases in temporary total disability *benefits;* it does not operate to increase a worker's wages. "Wages" referred to in ORS 656.206(1)(b) are determined according to ORS 656.210(2), which does not provide for a cost-of-living adjustment.

Claimant contends that the legislature could not have intended the unfair result of denying cost-of-living adjustments to a claimant receiving permanent total disability benefits. That position ignores that the legislature has provided for an increase in those benefits through the Retroactive Reserve. ORS 656.506(3).[1]

Affirmed.

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[1] ORS 656.506(3) provides, in part:

> "The purpose of the Retroactive Reserve is to provide increased benefits to claimants or beneficiaries eligible to receive compensation under the benefit schedules of ORS 656.204, 656.206, 656.208 and 656.210 which are lower than currently being paid for like injuries. However, benefits payable under ORS 656.210 shall not be increased by the Retroactive Reserve for claimants whoseinjury occurred on or after April 1, 1974. Notwithstanding the formulas for computing benefits provided in ORS 656.204, 656.206, 656.208 and 656.210, the increased benefits payable under this subsection shall be in such amount as the director considers appropriate. The director annually shall compute the amount which may be available during the succeeding year for payment of such increased benefits and determine the level of benefits to be paid during such year."

Cite as 117 Or App 42 (1992) December 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

**ALSEA VENEER, INC.**, an Oregon corporation;
Mo's Enterprises, Inc., an Oregon corporation;
Thompson's Sanitary Service, Inc., an Oregon corporation;
Willamette Valley Shade, Inc., an Oregon corporation;
Production Parts, Inc., an Oregon corporation;
Nobel & Bittner Plug Company, Inc., an Oregon corporation;
Green Transfer & Storage Company, an Oregon corporation, on their own behalf and on behalf of those similarly situated;
Donald M. Drake Co., an Oregon corporation;
Kaufman Crushing, Inc., an Oregon corporation;
Mt. Hood Meadows, Oreg., Ltd., an Oregon corporation;
Road & Driveway Paving, an Oregon corporation;
Staff Jennings, Inc., an Oregon corporation;
Griffith Rubber Mills, an Oregon corporation;
Stanley Investment and Management, Inc., an Oregon corporation;
Harsch Investment Corp., an Oregon corporation;
Barrett Mobile Home Transport, Inc., an Oregon corporation;
Oregon Manufactured Housing Association, an Oregon corporation;
and H. T. Rea Farming Corp., an Oregon corporation, *Appellants,*

v.

**STATE OF OREGON**, Anthony Meeker, Treasurer of State of Oregon, Oregon Department of Revenue and its Director, Richard Munn, and State Accident Insurance Fund Corporation, *Respondents.*
(88C-11289; CAA68787 (Control))

ABC ROOFING, CO., INC., an Oregon corporation, for itself individually and for all other persons similarly situated;
Abbott & Simpson Roofing & Sheet Metal, Inc., an Oregon corporation;
Associated Oregon Loggers, an Oregon nonprofit corporation;
Battles Construction Company, Inc., an Oregon corporation;
Baugham and Son, Inc., an Oregon corporation;
Beaver Plumbing & Heating, Inc., an Oregon corporation;
Brosterhous Construction Co., an Oregon corporation;
Chambers Plumbing and Heating, Inc., an Oregon corporation;
Clark Electric, Inc., an Oregon corporation;
Irving L. Wells, John M. Hansen and Dennis M. Baker, an Oregon partnership dba Clow Roofing & Siding Co.;
J.C. Compton Company, an Oregon corporation;
Dehaas & Associates, Inc., an Oregon corporation;
Donald M. Drake Company, Inc., an Oregon corporation;
Durbin Construction Co., an Oregon corporation;
Floyd Graham Construction Co., an Oregon corporation;
S & B James Construction Co., an Oregon corporation;
Ray D. Kalal dba Ray D. Kalal--Grading Contractor;
Neil Kelly Co., Inc., an Oregon corporation;
Morris P. Kielty General Contractor, Inc., an Oregon corporation;
L. P. Company, an Oregon corporation;
Meade & Greenlee, Inc., an Oregon corporation;
Morrison Electric Company, an Oregon corporation;
Morse Bros., Inc., an Oregon corporation;
Oregon-Columbia Chapter, The Associated General Contractors of America, Inc., an Oregon nonprofit corporation;
Oregon Concrete & Aggregate Producers Association, Inc., an Oregon nonprofit corporation;
Bill Page Construction, Inc., an Oregon corporation;

V. M. Philip & Son, Incorporated, an Oregon corporation;
Pioneer Masonry Restoration Co., Inc., an Oregon corporation;
Pioneer Waterproofing Company, Inc., an Oregon corporation;
Reimers & Jolievette, Inc., an Oregon corporation;
River Bend Sand & Gravel Co., an Oregon corporation, dba Salem Road & Driveway Co.;
Salem Wood Products, Inc., an Oregon corporation;
Slayden Holm, Inc., an Oregon corporation;
Sprick Roofing Co., Inc., an Oregon corporation;
Temp-control Mechanical Corp., an Oregon corporation;
Tigard Electric, Inc., an Oregon corporation;
Valley Concrete & Gravel Co., Inc., an Oregon corporation;
Fred Joyner and Sherry Joyner, dba Dial One Qwik Klip Maintenance and Perfection Bark Blowing;
and Rose City Electric, Inc., an Oregon corporation,
*Appellants,*

v.

STATE OF OREGON and State of Oregon by and through Anthony Meeker, in his capacity as Treasurer of the State of Oregon, and Anthony Meeker, in his capacity as Treasurer of the State of Oregon; State of Oregon by and through the Oregon Department of Revenue, and its Director, Richard Munn, and State Accident Insurance Fund Corporation, a public corporation, *Respondents.*
(88C-11300; CAA68788)
(Cases Consolidated)

Appeal from Circuit Court, Marion County.
Rodney W. Miller, Judge.
Argued and submitted September 14, 1992.
Jacob Tanzer, Portland, argued the cause for appellants. With him on the briefs were Bruce M. Hall, Richard H. Allan and Ball, Janik & Novack, Portland; Bruce C. Hamlin, Charles F. Hudson and Lane Powell Spears Lubersky, Portland.
William Gary, Special Assistant Attorney General, Eugene, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, Jack L. Landau, Deputy Attorney General, Virginia Linder, Solicitor General, Salem, Sharon A. Rudnick, Special Assistant Attorney General, Eugene, and Harrang Long Watkinson Arnold & Laird, P.C., Eugene.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P. J. Reversed and remanded.

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**117 Or App 47>** Plaintiffs appeal from a judgment entered after a consolidated trial in which 3 of their cases went to the jury, which found that defendants were not liable for breach of contract. The errors assigned on appeal relate primarily to pretrial rulings.

The Industrial Accident Fund (IAF) is a statutory "trust fund exclusively for the uses and purposes declared in [ORS 656.001 to ORS 656.794]," which relate to workers' compensation. ORS 656.634(1).[1]

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[1] ORS 656.634 provides:

"(1) The Industrial Accident Fund is a trust fund exclusively for the uses and purposes declared in this chapter, except that this provision shall not be deemed to amend or impair the force or effect of any law of this state specifically authorizing the investment of moneys from the fund.

"(2) Subject to the right of the State of Oregon to direct legislatively the disposition of any surplus in excess of reserves and surplus deemed actuarially necessary according to recognized insurance principles, and necessary in addition thereto to assure continued fiscal soundness ofthe State Accident Insurance Fund Corporation both for current operations and for future capital needs, the State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund."

The State Accident Insurance Fund Corporation (SAIF), an "independent public corporation," provides workers' compensation insurance to employers. Subject to the requirements of ORS 656.634, SAIF administers IAF and, in that sense, acts as a trustee. Funds received by SAIF become part of IAF, and IAF is the source for workers' compensation payments made by SAIF. ORS 656.632(2), (3). In September, 1982, the legislature, facing a state budget deficit, directed the transfer of $81 million from IAF, which it had determined had a surplus of over $168 million, to the State General Fund. Or Laws 1982 (Spec Sess 3), ch 2 (the Act). Section 1 of the Act sets forth extensive findings regarding the necessity for and appropriateness of the transfer. Section 2 directs the State Treasurer to transfer $81 million from IAF to the General Fund on or before June 30, 1983. Section 3 amends ORS 656.526, which grants SAIF the discretion to declare dividends, and Section 4 amends ORS 656.634 by adding language permitting the state to "direct legislatively the disposition of any surplus. "

SAIF opposed the Act in the legislature. When it was unsuccessful, it retained private counsel to initiate a lawsuit against the state, asserting that the Act was unconstitutional. In *Frohnmayer u. SAIF,* 294 Or 570,660 P2d 1061 (1983), the Supreme Court held that SAIF could not be represented by counsel other than the Attorney General without the Attorney General's consent. SAIF's challenge to the Act was subsequently dismissed for want of prosecution. In March, 1983, SAIF declared a 1982 dividend of $27 million.

After the Supreme Court's decision in *Frohnmayer v. SAIF, supra,* an employer insured by SAIF filed an action seeking, among other things, a declaration that the Act is unconstitutional and an injunction directing the state to return $81 million to IAF. In *Eckles* v. *State of Oregon,* 306 Or 380,760 P2d 846 (1988), the Supreme Court held that, before its amendment by Section 4 of the Act, ORS 656.634 "expressed a contractual promise of the state to employers who insured with SAIF that the state would not transfer IAF funds to the General Fund." 306 Or at 393. The court said that the legislature's amendment of the statute to permit the transfer of funds from IAF was a valid and effective modification of the contract as to persons who purchased insurance from SAIF after the amendment. However, "insofar as it affects employers with SAIF insurance contracts entered into before the enactment of the Transfer Act," section 4 of the Act was an impairment of the obligation of a contract, in violation of Article I, section 21, of the Oregon Constitution. However, the court held that section 2 of the Act, which mandates the transfer of funds, is not in violation of Article I, section 21, because it "does not purport to change the terms of the state's contract but to mandate a breach of that contract." 306 Or at 400. That breach is lawful, the court said, "given the general law of contractual obligations and the state's undoubted ability to breach its contracts through the use of its power of eminent domain."

In such cases, the court ruled, "the state is not obliged by Article I, section 21, to perform its contracts according to the terms of those contracts, at least where, as in this case, the contractual interests of the parties with whom the state has contracted are financial or property interests." In other words, a majority of the court held that Article I, **<117 Or App 48/49>** section 21, does not require specific performance ofthe state's contract when monetary damages would be adequate. Thus, the state cannot be required to return the funds to IAF. Article I, section 21, "protects contractual interests by obliging the state to compensate for its breach of those contracts. " 306 Or at 401. The court noted:

> "We cannot infer from the statutes alone that employers insured by SAIF were harmed by the transfer of funds. Nothing in the statutes makes employers liable to injured workers for shortfalls in the IAF. * * * Insured employers may benefit from premium reductions and dividends drawn from surplus IAF funds. *See* ORS 656.508 and 656.526. These benefits are set in the 'discretion' of SAIF. *See id.* That 'discretion' does not preclude a showing that insured employers were harmed by the transfer, but the existence of that harm cannot be presumed." 306 Or at 402 n 24.

It noted, further, that Eckles had neither sought compensation nor produced any evidence that he had been damaged by the state's breach of contract.

Plaintiffs seek to represent a class described as all employers who were insured by SAIF between July 1, 1981, and September 2, 1982. The 17 plaintiffs *in Alsea Veneer, Inc. v. State of Oregon (Alsea)* initially sought declaratory and injunctive relief for breach of contract, impairment of contractual obligations and violation of due process and prayed that the state be required to transfer $81 million to IAF and that SAIF be required to declare dividends or reduce premiums accordingly. They amended

their complaint to add a claim for unlawful taking of property and to pray for damages for breach of contract. The 40 plaintiffs in *ABC Roofing Company, Inc. v. State of Oregon (ABC)* seek damages for breach of contract and constitutional claims of impairment of the obligation of contract and the taking of private property without just compensation. The two cases were litigated se~aratelv until theY were consolidated for trial.

The trial court dismissed all equitable and constitutional claims in both cases for failure to state claims, ORCP 21, leaving only the claims for damages for breach of contract against the state and SAIF. It also denied certification of the class, which is alleged to include approximately 38,000 policy holders. The court granted summaryjudgment to defendants **<117 Or App 49/50>** on the claims of the individual plaintiffs who were insured on non-standard policies or who were not insured by SAIF during the relevant period. The case went to trial as to the remaining five plaintiffs. After they rested, the court granted SAIF's motion for directed verdict, because there was no evidence that SAIF had participated in the breach of contract. The court also directed a verdict for defendants on the claims of two of the five remaining plaintiffs, because there was no evidence of damages. The case went to the jury as to the three remaining plaintiffs for aggregate damages of $355. The jury returned a verdict for defendants that the state was not "liable for damages for breach of contract."

At the relevant time, three different types of policies were issued by SAIF: retrospectively rated policies (retro), group policies and standard policies. Plaintiffs include employers in each category. Each category is subject to different premium and dividend practices. Under retro policies, the premiums paid by policyholders are generally adjusted during the coverage period, on the basis of the employers' claims experience. Retro policy holders can limit the impact of individual large claims on premiums. Group plans permit a number of small insureds to combine their experience to obtain the benefits available to larger employers under retro plans. Standard plan holders are those not covered by either retro or group policies. Their premiums are determined at the beginning of the coverage period and are not adjusted for loss experience during the period.

Historically, all three types of policyholders have received dividends from surplus. Retro and group policies together accounted for nearly 80% of all premiums paid under SAIF policies during the 1981-82 fiscal year and over 90% of the dividends paid in 1983.

In their arguments to this court, both parties make certain assumptions that we reject. Plaintiffs assume that the Supreme Court's opinion in *Eckles* establishes, as a matter of law, that the state owes $81 million plus interest to the members of the proposed class. *Eckles* determined only that the state had breached its contract with SAIF's policyholders. It expressly did not determine the amount, or even the existence, of damages. 306 Or at 402 n 24. ORS 656.526 provides that the SAIF Board of Directors must periodically **<117 Or App 50/51>** assess the reserves of IAF and that, in its discretion, it may declare dividends out of surplus. The statute does not require the Board to declare a dividend or dictate the formula for the calculation of a dividend. Both matters are left to the Board's discretion. Whether the Board would have declared a larger dividend in March, 1983, if the state had not transferred $81 million from IAF is a question of fact, as is the question of how each individual policyholder might have been affected. On that basis, we reject plaintiffs' contention that the trial court erred in denying their motion for a partial directed verdict that the jury must award $81 million to plaintiffs.

Defendants assume that, because the jury considered evidence of both parties concerning the effect of the transfer and returned a verdict that defendants are not liable to three of the named plaintiffs for breach of contract, it necessarily determined that no plaintiff suffered damages. In the first place, the jury's verdict as to three plaintiffs has no preclusive effect with respect to the remaining plaintiffs or to the members of the proposed class. Additionally, we have no means of knowing how the jury reached its verdict or whether the outcome might have been different, if the case had been tried as a class action, and if equitable relief had been granted requiring SAIF to determine how it would have exercised its discretion with respect to what it would have done with the $81 million. For that reason, if there was error in not certifying the class and in denying equitable relief against SAIF, the errors are prejudicial and require reversal.

The trial court granted defendants' motions for partial summary judgment as to the claims of the retro and group policyholders. It ruled as a matter of law that retro and group policyholders would not have received any greater dividends if the surplus available for distribution had been $81 million greater.

There was evidence from which a jury could have found otherwise. Plaintiffs' actuarial expert testified that, if the $81 million had been available to SAIF in 1983, all policyholders would have received substantially larger dividends. SAIF's president at the time of the March, 1983, dividend declaration testified that the dividend would have been significantly larger if the available surplus had not been reduced by $81 million and that standard, group and retro policyholders would have shared proportionately in the **<117 Or App 51/52>** increased dividend. The evidence was sufficient to permit a jury to find that, without the transfer, dividends would have been greater for policyholders in all categories.

Plaintiffs assign error to the court's failure to certify the class. The question of certification is a legal one that involves issues of both law and fact. We review the trial court's factual determinations for substantial evidence and its legal conclusions for errors of law. *Bernard v. First Nat'l Bank,* 275 Or 145,550 P2d 1203 (1976). As a matter concerningjudicial administration, the trial court's assessment of the utility of a class action is entitled to "wide latitude." *Newman v. Tualatin Development Co. Inc.,* 287 Or 47,51,597 P2d 800 (1979) . ORCP 32A provides:

> "One or more members of a class may sue or be sued as representative parties on behalf of all only if:
>
> "A(1) The class is so numerous that joinder of all members is impracticable; and
>
> "A(2) There are questions of law or fact common to the class; and
>
> "A(3) The claims or defenses of the representative parties are typical of the claims or defenses of the class; and
>
> "A(4) The representative parties will fairly and adequately protect the interests of the class; and
>
> "A(5) In an action for damages under subsection (3) of section B. of this rule, the representative parties have complied with the prelitigation notice provisions of section H. of this rule. "

Only the criteria of subparagraphs A(2) through A(4) are in dispute here. We consider each of them in turn with regard to the proposed class.

The court concluded that the proposed class did not have "commonality," ORCP 32A(2), because "questions of law or fact, common to the proposed class, are not identifiable and are in many instances in conflict." The state contends that the only common issues among plaintiffs, such as the existence of a contract and a breach of the contract, do not call for adjudication, because they have already been resolved by the Supreme Court's opinion in *Eckles,* and that the remaining issues, such as each individual policyholder's entitlement to damages, are unique to each plaintiff. The trial court found **<117 Or App 52/53>** that the question of whether an insured had been damaged was an individual inquiry, as it must be under the court's decision in *Eckles.* In our view, however, there are common questions relating to damages that remain to be litigated in addition to the issues decided by *Eckles.* The first and foremost is what, if any, difference the transfer of $81 million made with respect to SAIF's declaration of dividends and determination of premiums with respect to each policy type. The fact that damages may be different with respect to the individual policyholders, or even that some policyholders may not be entitled to damages, does not negate the existence of the common legal and factual issues concerning the consequences of the transfer on SAIF's dividend and premium administration. We conclude that the proposed class satisfies the requirement of subparagraph (2).

The court held that the claims of the named plaintiffs were not typical, each to the other *or* to the claims of the proposed class. ORCP 32A(3). That requirement is satisfied if each claim "arises from the same event or practice or course of conduct that gives rise to the claims of members and [the] claims are based on the same legal theory." *Newman u. Tualatin Development Co. Inc., supra,* 287 Or at 50. Although the damages of the individual plaintiffs will vary, depending on policy type, loss experience and other factors, the claims of all class members arise from the same transaction and are based on the same contractual theory of liability. The fact that damages may differ among individual plaintiffs or that some plaintiffs may have suffered no damages does not render the claims atypical.

The court held that "the representative parties failed to demonstrate that they could adequately protect the interests of the proposed class because of the conflicting status of the varied SAIF Corporation policy holders." ORCP 32A(4). In this context, the interests of the class can be adequately protected if (1) there are no disabling conflicts of interest between the class representatives and the class; and (2) the class is represented by counsel competent to handle such matters. *See Penk v. Oregon State Board of Higher Education,* 93 FRD 45, 50 (D Or 1981). The state concedes that plaintiffs' counsel are competent to represent the proposed class.

**117 Or App 54>** The proposed class includes holders of the three types of policies; each policy type is also represented by the named plaintiffs. The state contends that the interests of the different policyholders diverge with respect to how SAIF might have allocated additional surplus and, in fact, that those interests conflict. For example, theoretically, the standard policyholders would benefit from a determination that SAIF would not have declared additional dividends to the retro and group policyholders, leaving more surplus for standard policyholders. Although, once again, damages may not be identical with respect to each policy type, each class member has a common interest in showing that, if the transfer had not occurred, SAIF would have paid larger dividends or reduced premiums. Differences in damages do not defeat typicality; they may be resolved with the creation of subclasses. ORCP 32G(2). We conclude that the proposed class satisfies the requirement of ORCP 32A(4).

Under ORCP 32B(3), a class action may be maintained if, in addition to the prerequisites of ORCP 32A:

> "The court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. Common questions of law or fact shall not be deemed to predominate over questions affecting only individual members if the court finds it likely that final determination of the action will require separate adjudication of the claims of numerous members of the class unless the separate adjudications relate primarily to the calculation of damages. The matters pertinent to the findings include: (a) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (b) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (c) the desirability or undesirability of concentratingthelitigationoftheclaimsintheparticularforum; (d) the difficulties likely to be encountered in the management of a class action; (e) whether or not the claims of individual class members are insufficient in the amounts or interests involved, in view of the complexities of the issues and the expenses of the litigation, to afford significant relief to the members of the class; and (f) after a preliminary hearing or otherwise, the determination by the court that the probability of sustaining the claim or defense is minimal."

**117 Or App 55>** The trial court concluded that a class action is not superior to other available methods for the fair and effective adjudication of the controversy. It addressed three of the six criteria in subsection B(3), specifically, (c), (d) and (f), and resolved them against certification. We conclude, once again, that each of the criteria wei~hs in favor of certification.

For reasons we have stated earlier, the common question of how the transfer affected SAIF's dividend and premium policy predominates, even with possible differences or conflicts between subclasses relating to how SAIF might have allocated the additional surplus. A single adjudication of that question is preferable to piecemeal litigation and potentially inconsistent awards. ORCP 32B(c). Class members are identifiable through SAIF's records. There is no indication that the class would be more difficult to manage than SAIF's annual administration of the dividends and premiums of its policyholders. Although the class is large, a single administration is undoubtedly less difficult than would be the management of the claims of each policyholder separately. ORCP 32B(d). The factor stated in subparagraph (e) points up, perhaps, one of the most persuasive reasons for certification. As illustrated by the three claims that went to trial here, the claims of the individual class members are not likely to be adequate to cover the costs of litigation.

In considering the factor stated in ORCP 32B(f), "the probability of sustaining the claim or defense," it is not appropriate for the court to determine whether plaintiffs are entitled to prevail; the court should only consider whether, from the evidence considered and the state of the law, plaintiffs' chances of prevailing "appear so minimal that they should be precluded from proceeding as a class action." *Newman v. Tualatin Development Co. Inc., supra,* 287 Or at 51. After *Eckles,* we cannot characterize plaintiffs' chances of prevailing as being that minimal.

Although, in our consideration of whether the class should have been certified, we give great latitude to the trial court, in view of the fact that each of the considerations in ORCP 32A and B weigh in favor of certification we conclude that the court erred in not certifying the class.

**117 Or App 56>** We affirm the trial court's dismissal of the equitable claims of the *Alsea* plaintiffs against the state. Those plaintiffs argue that a complete remedy must require the state to return $81 million to IAF so that SAIF and its Board of Directors may declare dividends or reduce premiums for the year in question in a manner consistent with good faith. In *Eckles,* the Supreme Court rejected that contention, holding that, under Article I, section 21, the state is not obliged to return the funds. 306 Or at 401-03.

We also conclude that it was appropriate for the court to allow SAIF's motion for a directed verdict on the breach of contract claims. There was no evidence that SAIF had breached its contract with plaintiffs; plaintiffs have no claim for money damages against SAIF. It would not have been appropriate for the damages claims against SAIF to have gone to the jury. Nonetheless, SAIF should not have been dismissed from the case. ORS 30.320 requires that a suit or action against the state be brought "by and through and in the name of the appropriate State agency upon a contract * * * made by such agency and within the scope of its authority." The state contracted with SAIF policyholders through SAIF, and SAIF is therefore a necessary party. Additionally, SAIF's presence is necessary for plaintiffs to obtain complete relief on their only cognizable claim for damages for breach of contract by the state. Only SAIF can determine how the transfer of $81 million from IAF affected its March, 1983, dividend declaration and the premiums that it charged plaintiffs. Plaintiffs are entitled to compel SAIF to determine how it would have exercised its discretion if it had had the extra $81 million in 1983.

Plaintiffs contend that the court erred in refusing to admit a copy of the Act in evidence. The court was correct that it is the court's responsibility to instruct the jury as to the law.

Reversed and remanded.

Cite as 117 Or App 128 (1992) December 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard A. Colclasure, Claimant.

Richard A. **COLCLASURE**, *Petitioner,*
v.
**WASHINGTON COUNTY SCHOOL DISTRICT NO. 48-J**, *Respondent.*
(88-15666; CA A67543 (Control))

In the Matter of the Compensation of Richard Colclasure, Claimant.

Richard COLCLASURE, *Petitioner,*
v.
BEAVERTON SCHOOL DISTRICT NO. 48-J, *Respondent.*
(89-05949; CAA67666)
(Cases Consolidated)

In Banc
Judicial Review from Workers' Compensation Board.
Merrill Schneider, Portland, argued the cause and filed the brief for petitioner.
Patric J. Doherty, Portland, argued the cause for respondents. With him on the brief was VavRosky, MacColl, Olson, Doherty & Miller, P.C., Portland.
DEITS, J.
Affirmed on both petitions.
Buttler, J., concurring.
Durham, J., dissenting.

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**117 Or App 130 >** In the first of these consolidated petitions, claimant seeks review of the Workers' Compensation Board's reversal of a referee's order reversing the decision of the Director of the Department of Insurance and Finance (Director) that claimant is not eligible for vocational assistance. In the second petition, claimant seeks reversal of the Board's decision that he was not entitled to vocational assistance between the time that the referee found him eligible and the time that the Board reversed the referee. We affirm both orders.

The basis for the Director's decision that claimant is not eligible for vocational assistance was that claimant had left his job for reasons unrelated to his compensable injury. The Director concluded, "There is no causal link between the injury and the need for vocational assistance." *See* OAR 436-120-040(7); OAR 436-120-045(3). Claimant sought a hearing before the referee, who made findings, including that claimant *did* leave his job for reasons related to the injury and concluded that claimant is eligible for assistance. Employer sought Board review. The Board concluded, in effect, that the referee exceeded his review authority under the limited authority that ORS 656.283(2) provides for "modifying" a decision of the Director concerning eligibility for vocational assistance. The Board reasoned that the evidentiary record before the referee supplied a reasonable basis for the Director's finding, whether or not it also supported the opposite finding of the referee, and that, therefore, the Director did not abuse his discretion and, under ORS 656.283(2), his decision could not be modified.

ORS 656.283(2) allows a modification of the Director's decision only if it

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedures; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

Claimant argues that the Board interpreted ORS 656.283(2) too narrowly and that, under a proper interpretation, the <117 Or App 130/131> referee is the primary fact finder and may reverse an eligibility decision by the Director if the facts that the referee finds differ from the facts on which the Director relied, explicitly or implicitly.[1]

In *Lasley v. Ontario Rendering*, 114 Or App 543,836 P2d 184 (1992), we construed the unusual review procedures of ORS 656.283(2):

> "Under ORS 656.283(2), the hearing to which a claimant is entitled must be for the purpose of determining the historical facts relevant to the dispute. That responsibility is unaffected by the scope of review limitations in subsections (a) through (d). On the basis of that record, the referee may make findings of ultimate fact to determine whether the Director's order is subject to modification for any of the specific reasons in ORS 656.283(2). On review, to determine whether to Director's order is subject to modification, the Board reviews the record made by the referee but may make findings of ultimate fact different from those made by the referee. This court, however, reviews the Board's decision only for errors of law and substantial evidence. ORS 656.298; ORS 183.482."

In this case, it is necessary to decide the effect of findings made by the referee and the Board in performing their limited scope of review in this type of case. Although claimant recognizes that the language of ORS 656.283(2) defines the grounds for modification of a Director's decision by the referee or Board, he argues that the Director's decision can be reversed if the referee or Board find facts different from the ones found or relied on by the Director. We disagree. There are numerous statutes in Oregon giving reviewing courts and agencies the authority to reverse an erroneous finding or errors in the fact finding process. Had the legislature intended the Director's decision to be subject to modification because of a fact finding error, it could have said so, as it has done in those other instances.

Claimant is not aided by his attempt to characterize the Director's decision as an abuse of discretion. Although some decisions involving the determination or application of facts might constitute an abuse of discretion, the *only* error <117 Or App 131/132> that is or can be asserted here is that, according to the referee, the Director was incorrect in his finding. It would be inconsistent with the purpose of the statutes relating to vocational rehabilitation--to encourage informal and expeditious resolution of vocational assistance disputes--to allow a decision by the Director to be reversed on a ground that the statute does not permit simply by relabeling it.[2]

The dissent would hold that the Board was incorrect in its starting premise that the referee is not the "primary fact finder" and that, therefore, we should remand to the Board for reconsideration under a correct understanding of the role that the statute assigns the referee. The dissent's point is wholly unresponsive to the decisive issue--whether the Director's decision can be reversed by the referee solely because their views of the facts differ. If the Board's understanding of the statute was wrong in the way that the dissent maintains, the most that the dissent demonstrates is that the Board's holding was right for the wrong reasons. No purpose can be served by requiring the Board to reconsider the case under a different understanding of the statute when both understandings must lead to the same result. Labeling the referee as the "primary fact finder" does not alter the clear impact of the statutes that an error of fact cannot serve as a basis in itself for reversing the Director's decision.

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[1] The Director is not required to conduct a hearing or to make findings. Here, however, he did make what amounted to findings.

[2] We said in *Lasley v. Ontario Rendering, supra*, that, after conducting the hearing, "the referee may make findings of ultimate fact to determine whether the Director's order is subject to modification for any of the specific reasons in ORS 656.283(2)." 114 Or App at 547. That language is not contrary to our conclusion here that a referee's finding of fact that differs from the Director's express or implied finding on the same question cannot serve as a basis for modification. That issue was not presented or decided in *Lasley*. The language in *Lasley* concerns a situation where a finding by the referee gives rise to a modification based on one of the four grounds specified in ORS 656.283(2). For example, if the referee had found that the Director decided a claim by flipping a coin or that he had refused to give the parties an equal opportunity to present their positions, modification of the decision on that basis would be permissible under one of the statutory grounds. *Lasley* did not add a fifth ground not found in the statute.

Claimant also argues that, under the Board's interpretation of ORS 656.283(2) and presumably ours, he was denied a meaningful hearing and his due process rights were violated. He reasons that the Director conducts *no* hearing and that the referee's hearing is essentially a meaningless exercise that can result in no relief, at least none based on any **<117 Or App 132/133>** facts disclosed at the hearing. Claimant relies on *Carr v. SAIF,* 65 OrApp 110,670 P2d 1037 (1983), *reu dismissed* 297 Or 83 (1984), where we held that the claimant had a corlstitutionally protected property interest in temporary total disability benefits and that their payment could not be suspended without an appropriate hearing and related procedures. This case differs in that claimant never became eligible for vocational assistance. He had no property interest before an eligibility decision. The court said in *Board of Regents v. Roth,* 405·US 564, 577, 925 S Ct 2701, 33 L Ed 2d 548 (1972), as we quoted in *Carr v. SAIF, supra,* 65 Or App at 117:

> "To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it."

We do not find claimant's constitutional argument persuasive.[3]

Our disposition of the arguments that we have addressed makes it unnecessary for us to reach the other contentions that claimant makes in connection with the first petition.

In his second petition, claimant argues that he was entitled to vocational services between the time of the referee's and the Board's decisions. He relies on the version of ORS 656.313(1) that was in effect at the relevant times and on *former* ORS 656.313(4), that was repealed by Or Laws 1990, ch 2, 23. ORS 656.313(1) then required payment of "compensation" during the pendency of Board and court review initiated by an employer. Subsection (4) provided:

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

Vocational assistance is governed by ORS 656.340. Although, unlike medical service payments, it was not specifically excluded by *former* ORS 656.313(4), neither was it **<117 Or App 133/134>** specifically included. Claimant relies on *Georgia-Pacific v. Hughes,* 305 Or 286, 751 P2d 775 (1988), where the court held that, although the claimant's interim compensation was payable under ORS 656.262, which is not one of the statutes enumerated in *former* ORS 656.313(4), it was nevertheless "compensation" for the purposes of ORS 656.313 because the nature of interim compensation is the same as the types of compensation listed in ORS 656.313(4), namely death and permanent total disability, temporary total disability and permanent partial disability.

As the Board's opinion explains, the payments that were included under *former* ORS 656.313(4) are those "that are paid directly to the claimant to replace or supplement wages or loss of earnings." The purpose of ORS 656.313 was to prevent employers "from taking away sources of income" and thereby "wearing down" injured workers during the review process. The Board concluded that vocational assistance "is not a benefit which directly provides for maintenance of the injured worker," and it is not a form of compensation for purposes of ORS 656.313.[4] ORS 656.313(4) does not include vocational assistance in its definition of compensation, and we agree with the Board that it should not he read into the statute.

Affirmed on both petitions.

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[3] The basis for our rejection of the argument makes it unnecessary tor us to decide whether its other premises are correct.

[4] Vocational assistance may be a form of compensation under other provisions of the workers' compensation law. *See SAIF v. Seuerson,* 105 Or App 67, 803 P2d 1203 (1990). *modified* 109 OrApp 136, 817 P2d 1352 (1991).

**BUTTLER, J., concurring.**

Although I agree generally with the majority's disposition of the case, its discussion of the review of the decision of the Director of the Department of Insurance and Finance with respect to claimant's eligibility for vacational assistance is confusing. It is apparent that the language from *Lasley v. Ontario Rendering,* 114 Or App 543,836 P2d 184 (1992), that is quoted by, and relied on, by both the majority and the dissent, is ambiguous. Rather than attempt to explain my understanding of that language, I will simply state that I believe that the Board in this case was correct.

**117 Or App 135>** The essence of the Board's decision is that the referee's function at the hearing to which claimant was entitled is to make a record. On the basis of that record, the referee determines whether the Director's order involved an abuse of discretion, assuming that his order was based on the record made by the referee. The referee does not determine how the evidence preponderates or whether there is substantial evidence to support the Director's order. The Board then reviews the same record and makes the same ~etermination. In this case, the Board held that it can reasonably be concluded from the record made at the hearing that claimant left work because of a noncompensable psychological condition. Accordingly, it reversed the referee and affirmed the Director's order. The Board was correct with respect to both the filnction of the referee and of the Board.

Concededly, the statutory process dictated by ORS 656.283(2) is peculiar and, perhaps, unfair to claimants. However, that is a question for the legislature to resolve.

Warren, Rossman and Edmonds, JJ., join in this concurring opinion.

**DURHAM, J., dissenting.**

In this proceeding under ORS 656.283(2), the issue is whether the referee and the Board can base their review decision on factual findings from the hearing record that differ from the factual determinations of the Director. We considered that question in *Lasley v. Ontario Rend ering,* 114 Or App 543, 547, 836 P2d 184 (1992), and held that the referee's responsibility to find the historical facts is unaffected by the review limitations in ORS 656.283(2):

> *"Under ORS 656.283(2), the hearing to which a claimant is entitled must be for the purpose of determining the historical facts relevant to the dispute. That responsibility is unaffected by the scope of review limitations in subsections (a) through (d).* On the basis of that record, the referee may make findings of ultimate fact to determine whether the Director's order is subject to modification for any of the specific reasons in ORS 656.283(2). On review, to determine whether the Director's order is subject to modification, the Board reviews the record made by the referee but may make findings of ultimate fact different from those made by the referee. This court, however, reviews the Board's decision **<117 Or App 135/136>** only for errors of law and substantial evidence. ORS 656.298; ORS.482." (Emphasis supplied.)

The majority alters the referee's role, holding that the referee must defer to implicit or explicit "findings" by the Director.[1] Because that misstates the referee's responsibility and contradicts *Lasley, I* dissent.

The Director held no hearing and made no evidentiary record. He concluded, on the basis of his informal review, that there was no causal link between claimant's back injury and the need for vocational assistance and that he had left his job due to psychological stress, not because of an inability to perform. After a hearing, the referee concluded that claimant was eligible for vocational assistance, because he had left his "custodian job on medical advice that work of that type would cause additional low back surgery in the future. " On review, the Board reversed, but misstated the referee's factfinding responsibility:

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[1] The majority incorrectly assumes that the director makes findings of fact to support his proposed resolution. Whether findings accompany the director's order is fortuitous because, as *Lasley v. Ontario Rendering, supra,* noted:

> "Neither the statute nor the administrative rule requires the Director to hold a hearing, to create a record or to make findings in support of his decision on a vocational assistance matter." 114 Or App 546.

> "The referee does not determine how the evidence preponderates or even if there is substantial evidence to support the director's order."

The Board held that the scope of review limitations in ORS 656.283(2)(a)-(d) restrict the referee's role as factfinder and require him to defer to the Director's view of the facts unless it is "clearly against reason and evidence."

As *Lasley* demonstrates, that analysis is incorrect. The referee finds the historical facts. Even the majority acknowledges that, accordingto *Lasley,* the referee and Board follow their ordinary hearing procedures in hearing the evidence and finding the facts. On the basis of the findings, the referee determines whether the Director's decision is erroneous under ORS 656.283(2)(a)-(d). The referee does not merely determine, as the Board erroneously held, whether any evidence supports the Director's decision. As *Lasley* held, nothing in the statute suggests that the legislature intended **<117 Or App 136/137>** the statutory review limitations to alter the referee's responsibility to find the historical facts.

The majority is not correct in suggesting that that reading of *Lasley* would add "factual error" to the grounds for modification in the statute. The Board and the majority assume that the Director's decision is based on an administrative hearing that results in findings based on evidence and a decision based on those findings. The assumption is false. The parties' only opportunity for an administrative hearing is that which occurs before the referee and the Board. The findings from that hearing state the factual context in which the Board reviews the Director's decision under ORS 656.283(2). The Board has no reason to decide whether the Director made an "error of fact," because the Board relies solely on its own findings. It does not examine whatever factual assumptions the Director may have made, because they are irrelevant to the Board's review. *Lasley* correctly held that the relevant facts are those found by the referee and the Board. The majority ignores *Lasley* in declaring that the Board is forbidden to determine the facts and rely on its own findings and is compelled to agree with the Director's factual impressions, even though they may be strongly contradicted by the evidence submitted to the referee.[2]

The majority's restriction on Board review creates a serious practical problem that the Legislature clearly did not intend. ORS 656.283 entitles any party to a *hearing,* including the usual administrative procedures that accompany a hearing, such as findings based on the record and a decision based on findings supported by substantial evidence. Even **<117 Or App 137/138>** though the Director holds no hearing, receives no evidence, finds no facts or makes incomplete findings and publishes no final order, the majority holds that the parties are confined to the Director's factual impressions, such as they are, and may not adduce evidence before the referee to establish facts different than those assumed by the Director. That construction effectively eliminates the right to a hearing before the Board. The net result is that, under the majority's construction, the parties have no right to a true hearing before either the Director or the Board. We cannot ascribe to the legislature an intention to create such an absurd result.

We should adhere to *Lasley* and remand this proceeding to the Board for reconsideration under a correct interpretation of the law. The referee did not err in finding the historical facts and reviewing the Director's decision in the light of those findings. Under *Lasley,* that is precisely the responsibility of the referee and the Board. I cannot concur in the majority's creation of a convoluted procedural restriction that is unsupported by the statute or common sense.

I dissent.

Riggs and De Muniz, JJ., join in this dissent.

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[2] The Director found no evidence that claimant stopped working because of a worsening of his back condition. However, the referee found:

> "The undisputed testimony at the hearing was that claimant left the custodian job on medical advice that work of that type would cause additional low back surgery in the future. The undersigned is not aware of any statute rule or case law that requires claimant to endanger himself in order to satisfy vocational eligibility rules."

The referee's finding, if accepted by the Board, would support a conclusion that the Director violated a statute or rule or abused his discretion. ORS 656.283(2)(a), (d). However, the Board erroneously believed that it was obligated to ignore the referee's finding if "any evidence" in the record supported the Director's factual determination. This court should instruct the Board that, under the statute and *Lasley v. Ontario Rendering, supra,* the Board is obligated to review the Director's decision on the basis of its own findings of historical fact.

Cite as 117 Or App 176 (1992) December 16, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Howard R. Mather, Claimant.

**SM MOTOR CO.**, *Petitioner,*
v.
Howard R. **MATHER**, *Respondent.*
(90-21041; CA A72515)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 30, 1992.
Darren L. Otto, Portland, argued the cause for petitioner. With him on the brief was Scheminske & Lyons, Portland.
Max Rae, Salem, argued the cause and filed the brief for respondent.
Before Joseph, Chief Judge, and Deits and Durham, Judges.
JOSEPH, C. J.
Affirmed.

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**117 Or App 178>** Employer seeks review of an order of the Workers' Compensation Board affirming and adopting the referee's order holding claimant's aggravation claim compensable. We affirm the Board and write only to address the question of the timeliness of the claim.

The referee's findings are not challenged: Claimant suffered a compensable neck and upper back injury in 1984 while working as a mechanic. The referee found that the injury had "resulted in no temporary or permanent disability compensation." The claim was closed in August, 1985.[1]

Claimant suffered intermittent neck pain after his claim was closed, until January, 1987, when he requested that it be reopened. Employer denied the request. The parties entered into a disputed claim settlement, which a referee approved in November, 1988. The agreement provides, in part:

> "1. [Employer] will rescind its January 8, 1987 and April 13,1987 denials only insofar as it applies to claimant's upper back and neck. Claimant's claim remains nondisabling. "

In August, 1989, claimant went to Dr. Flora and then to Dr. Gibson, his family physician, complaining that he had more neck pain. Gibson referred claimant to Dr. LaFrance, a neurologist, who diagnosed a herniated disc. On August 15, 1990, claimant's attorney sent employer's insurer a letter requesting that the claim be reopened. On August 16, 1990, Gibson wrote the insurer, explaining claimant's condition:

> " [Claimant's] symptoms of paresthesias in the right arm and hand have progressed in the several months that I have been his physician. He currently has continual dysesthesias on the medial aspect of the right arm, forearm, and hand from the axilla to the fingers. This discomfort is worsened by having his arms raised over his head or holding his arms out for extended periods. This limits his ability to perform several jobs in his employment as a mechanic. These symptoms are a result of the disc herniation at C5-6. The symptoms are **<117 Or App 178/179>** permanent and constitute a permanent work disability from the injury of 12-18-84."

The insurer did not treat either the attorney's letter or the doctor's report as an aggravation claim and did not begin paying benefits. Claimant requested a hearing.

ORS 656.273(4) provides:

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[1] Exhibit 6, the claim form, shows that employer accepted the claim as disabling. Exhibit 12, the notice of closure, shows that claimant was awarded compensation for three days of temporary disability.

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.

"(b) If the injury has been in a nondisabling status for one year or more after the date of the injury, the claim for aggravation must be filed within five years after the date of injury."

Employer contends on review, for the first time, that the claim is untimely, because claimant's aggravation rights expired on December 18, 1989, 5 years after the date of the original injury. The issue of timeliness was not raised before the referee or the Board, so the Board did not consider it. However, the parties apparently agree that the question is jurisdictional and that we can consider it on review.

The Board has held that a referee lacks "jurisdiction" to consider a claim that has not been filed within the time limitation of ORS 656.273(4). *Timothy D. Beard,* 43 Van Natta 432 (1991); *Denise A. Robinson,* 42 Van Natta 2514 (1990). Because it considers the requirements of ORS 656.273 to be jurisdictional, the Board would undoubtedly conclude that the question of the timeliness of a claim can be raised at any stage of the proceedings.

We have never addressed the question squarely. In *Nelson v. SAIF,* 43 OrApp 155, 159, 602 P2d 341, *rev den* 288 Or 173 (1979), we said:

"It is undisputed that claimant did not request a hearing on the denial within the time required [by ORS 656.319(1)].

"The benefits awarded under the workers' compensation law are purely statutory, and a claimant must strictly follow the prescribed procedures in order to recover under the law. *Gerber v. State. Ind. Acc. Com.,* 164 Or 353, 101 P2d 416 (1940). *Time limitations prescribed by law are limitations upon the right to obtain compensation and are not subject to* **<117 Or App 179/180>** *exceptions contained within the general statute of limitations. Lough v. State Industrial Acc. Com.,* 104 Or 313, 207 P 354 (1922). *Neither the Board nor the courts may waive these requirements. Johnson v. Compensation Department,* 246 Or 449, 425 P2d 496 (1967); *Rosell v. State Ind. Acc. Com.,* 164 Or 173, 95 P2d 726 (1940)." (Emphasis supplied.)

Although we did not say it in so many words, we draw from *Nelson* the conclusion that the time limitations for filing a claim, which may not be waived by a party *or by the court,* are jurisdictional. Accordingly, we conclude that a filing timeliness argument may be raised at any time and that we must consider employer's contention that the claim was not timely filed.

Generally, under ORS 656.273(4)(a), an aggravation claim must be filed within 5 years after the first determination order or the first notice of closure. If, however, the injury "has been in nondisabling status for one year or more after the date of the injury," ORS 656.273(4)(b), a claimant has 5 years after the date of the injury within which to file an aggravation claim. Therefore, the present claim is timely, if it is subject to ORS 656.273(4)(a); it is not timely, if it is subject to ORS 656.273(4)(b).

There is no statutory definition of "nondisabling status." Under ORS 656.005(7)(d), a nondisabling injury is one that requires medical services only. Because claimant had 3 days of temporary disability after his injury, it was not nondisabling under that definition. We note that claimant had no permanent disability; however, employer does not contend that the injury was nondisabling when it was closed and, therefore, subject to ORS 656.273(4)(b).

In the settlement of the 1987 aggravation claim, the parties agreed that the claim "remains non-disabling." More than 1 year passed after the referee's November 9, 1988, approval of that settlement before the filing of the current aggravation claim. Employer contends that, by virtue of the settlement and the referee's order approving it, the claim was nondisabling as of November 9, 1988, and "for one year or more after the date of the injury." It asserts, consequently, that, under ORS 656.273(4)(b), claimant had only 5 years from the 1984 injury within which to file the claim and that the claim is therefore untimely.

**117 Or App 181>** Employer assumes that the 1-year period without disability, which is a predicate to the applicability of ORS 656.273(4)(b), may begin at any time within 5 years after the injury. As we read ORS 656.273(4)(b), it applies only to injuries that were nondisabling at the beginning *and remain so* for at least 1 year after the original injury. Because claimant's injury was initially disabling, we conclude that it is subject to the limitation in ORS 656.273(4)(a). Claimant had 5 years after the notice of closure within which to file an aggravation claim. The claim was, therefore, timely.

We also conclude that Gibson's letter of August 16, 1990, constituted a claim for aggravation and that there is substantial evidence to support the Board's determination that the claim is compensable.

Affirmed.

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Cite as 117 Or App 198 (1992) December 16, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lisa Walleri, Claimant.

Lisa **WALLERI**, *Respondent*,
v.
THE **FEDERAL HOME LOAN BANK** OF SEATTLE and Aetna Casualty & Surety Company, *Appellants*.
(C 91 0012 MI; CA A71724)

Appeal from Circuit Court, Washington County.
Donald Ashmanskas, Judge.
Argued and submitted July 22, 1992.
Darren L. Otto, Portland, argued the cause for appellants. With him on the briefs was Scheminske & Lyons, Portland.
Tomas Finnegan Ryan, Portland, argued the cause and filed the brief for respondent.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
RICHARDSON, P. J.
Reversed and remanded with instructions to dismiss petition.

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**117 Or App 200>** Employer appeals the circuit court judgment awarding claimant's counsel's additional fees under *former* ORS 656.388(2). It argues that the circuit court did not have jurisdiction, because its statutory authority had been repealed. We reverse.

In March, 1989, claimant filed a workers' compensation claim. Employer's subsequent denial was overturned by the referee on April 1, 1991. Claimant's counsel requested $33,000 attorney fees, but the referee awarded him $10,000. The attorney filed a petition for additional fees in the circuit court pursuant to *former* ORS 656.388(2)[1] on June 13, 1991. Employer's motion to dismiss the petition was denied, and the court allowed an additional $15,000 as attorney fees.

ORS 656.388 was amended in 1990 to eliminate subsection 2. Or Laws 1990, ch 2, 30. Claimant contends that, under Oregon Laws 1990, chapter 2, section 54, the amendment does not apply to his petition for attorney fees. He argues that, because claimant's request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, the former version of ORS 656.388 applies. Or Laws 1990, ch 2, 54; *see SAIF v. Herron*, 114 Or App 64,836 P2d 131 (1992). There is nothing in the 1990 legislation, he contends, that shows an intention that the repeal of subsection 2 be applied retroactively.

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[1] *Former* ORS 656.388(2) provided:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

Employer argues that section 54(2) of the 1990 session law does not apply, because a request for attorney fees is not a "matter regarding a claim" to which the law in effect before July 1, 1990, applies. Because the amendment of ORS 656.388 had become effective, the circuit court had no jurisdiction over the attorney fees petition filed June 13, 1991.

Generally, a law that repeals a court's jurisdiction takes away the right to proceed in that court at the time the **<117 Or App 200/201>** law becomes effective. *Libby v. Southern Pac. Co.*, 109 Or 449, 219 P 604,220 P 1017 (1923). Under certain circumstances, a court may retain jurisdiction to rule on cases pending in that court. *Libby v. Southern Pac. Co., supra; Russell et al u. Pac. Maritime et al, 9* Or App 402, 496 P2d 252, *rev den* (1972). However, if a case is not pending in the court where jurisdiction reposed before the amendment, the new procedures apply in the absence of a savings clause in the repealer. *Trueblood v. Health Division,* 28 Or App 433, 559 P2d 931, *rev den* 278 Or 621 (1977).

Claimant's counsel's petition was not pending in the circuit court the day the circuit court lost jurisdiction to determine attorney fees under the former statute. The workers' compensation claim was pending before the referee on July 1,1990, but attorney fees are not compensation, *Dept. of Justice Inmate Ins. Fund v. Hendershott,* 108 Or App 584, 816 P2d 1178 (1991), and the fees petition in circuit court was not part of, or a matter, regarding a claim. Or Laws 1990, ch 2, 54. The circuit court erred by denying employer's motion to dismiss the petition.

Reversed and remanded with instructions to dismiss petition.

Cite as 117 Or App 219 (1992) December 16,1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Heather I. Smith, Claimant.

**SAFEWAY STORES, INC.**, *Petitioner,*
v.
Heather I. **SMITH**, *Respondent.*
(90-20768; CA A72498)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 15, 1992.
Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. With him on the brief was Meyers & Radler, Portland.
Daryll E. Klein, Milwaukie, argued the cause for respondent. With him on the brief was Francesconi & Associates, Milwaukie.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.

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**117 Or App 226>** Employer seeks review of an order of the Workers' Compensation Board remanding claimant's claim for acceptance and processing. We affirm.

In 1988, employer accepted claimant's claim for tendinitis of the right wrist and forearm as a non-disabling injury. The claim was closed with no award of permanent disability, and claimant lost no time from work because of the condition. In May, 1989, claimant was experiencing pain in her elbow, neck and shoulder. Dr. Treible reported the symptoms to employer at that time. The claim was reopened as an aggravation. Employer accepted the aggravation claim as disabling, but did not specify the condition that was accepted. Claimant underwent surgery on her right wrist, returned to modified work and participated in physical therapy. By January, 1990, she was experiencing pain in both wrists and was referred to a specialist, Dr. Kemple, who became her treating physician. In March and April, Kemple reported that claimant was experiencing pain in her hands, wrists, arms, neck and shoulder. He subsequently released claimant from work.

Claimant's aggravation claim was closed by a determination order awarding her temporary disability from the date of the onset of the aggravation, May 11, 1989, to her medically stationary date, September 5, 1990. She was also awarded permanent partial disability for loss of use of her right forearm. The day after the determination order issued, claimant requested a hearing, asking that employer's *de facto* denial of her bilateral neck, shoulder and arm condition be set aside. The referee set aside the denial and found that "[c]laimant's right wrist condition and work activities are the major contributing cause of her neck/shoulder/arm syndrome." He ordered that the claim be remanded to employer for acceptance and awarded attorney fees to claimant.

Employer appealed to the Board, which upheld the referee, agreeing that, when claimant's physicians reported to employer concerning her wrist, neck, right shoulder and left arm condition, that was not only a claim for an aggravation of the original wrist injury, but was also a claim involving the different body parts. The Board agreed with the referee **<117 Or App 226/227>** that claimant had established the compensability of her other conditions.

Employer acknowledges that, if a claim is not accepted or denied within the statutory time limit, the claim is deemed denied *de facto. Barr v. EBI Companies, 88* Or App 132, 134, 744 P2d 582 (1987). However, it argues that claimant did not file a claim on which the Board could find that there was a *de facto* denial. Employer contends that the mention of claimant's other conditions in the doctors' reports did not constitute a claim requiring a response, because

> "the diagnosis of such complaints was not a claim in the absence of the showing of a need for medical services or entitlement to disability benefits in addition to those being provided for the accepted medical condition."

ORS 656.005(6) defines a claim as

> "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

Compensation is defined as

> "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8).

We agree with the Board that, under those statutes, a physician's report requesting medical treatment for a specified condition constitutes a claim.

The Board found that the physician's reports advised employer of the additional conditions and requested treatment for those conditions:

> "[A]s early as May 30, 1989, the employer received medical reports from Dr. Trieble *[sic]* that, in addition to pain in the right wrist and forearm, claimant had pain in her elbow, trapezius and shoulder. Trieble *[sic]* 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 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 **<117 Or App 227/228>** 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." (Emphasis supplied.)

We agree with the Board's conclusion that the doctors' reports were an additional claim. Therefore, the Board did not err in concluding that employer's failure to respond within 60 days constituted a *de facto* denial of responsibility for the other conditions.

Employer also argues that the Board erred in concluding that claimant's bilateral neck, shoulder and arm conditions were a compensable consequence of her 1988 injury. She was required to show that her compensable condition was the major contributing cause of her neck, shoulder and arm problems. *See* ORS 656.005(7)(a)(A). The Board concluded that the evidence showed that the compensable condition was the major contributing cause of her current condition.

Employer's principal complaint is that the Board's holding is not supported by substantial evidence. In particular, employer challenges the Board's reliance on the opinion of Dr. Fraback, who evaluated claimant's condition in January, 1991. Fraback discussed claimant's condition and 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.

Employer reads Fraback's opinion differently than did the Board. However, the Board explained its reading, and its reasons for not relying on evidence that employer urges is persuasive. The Board's interpretation of the evidence is not unreasonable and, accordingly, we hold that its conclusion is supported by substantial evidence.

Affirmed.

Cite as 117 Or 242 (1992) December 16, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Floreen A. Popoff, Claimant.

Floreen A. **POPOFF**, *Petitioner,*
v.
**J.J. NEWBERRYS**, *Respondent.*
(88-12024, 88-12023, 88-19685; CA A70090 (Control), A70091)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1992.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Michael R. Stebbins and Stebbins & Coffee, North Bend.

Jerald P. Keene, 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 Deits and Durham, Judges.

DURHAM, J.

Affirmed.

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**117 Or App 244>** Claimant seeks review of an order of the Workers' Compensation Board that held that claim preclusion bars her from asserting claims for medical services. ORS 656.245. We affirm.

Claimant compensably injured her back in 1979. The claim was closed by stipulation and order in 1985. Claimant experienced back pain in 1986 after falling down. She saw Dr. Holbert, who diagnosed obesity and degenerative disc disease and recommended weight loss as an alternative to surgery. Two months later, Dr. Wolpert made the same diagnoses but opined that claimant's symptoms were related to the compensable injury. In February, 1987, she filed a claim for medical services. In March, employer denied the claim. Claimant did not request a hearing. In November, 1987, and April and June, 1988, she filed additional claims for medical services with employer. It did not respond. On June 4, claimant requested a hearing.

The Board held that employer's March, 1987, denial rejected claimant's claim for medical services for a back condition. It found that the back condition had not changed since the denial. It held that, because she had failed to request a hearing from the denial, she was barred from asserting that she was entitled to compensation for medical services for the same condition.

Claimant assigns error to the Board's conclusion that her failure to request a hearing on the 1987 denial barred her from asserting the later claims for medical services. She argues that the 1987 claim was never litigated and that, therefore, claim preclusion does not apply. However, claim preclusion does not require actual litigation. The doctrine applies when there is an opportunity to litigate an issue before a final determination of the proceeding. *Drews v. EBI Companies,* 310 Or 134, 140, 795 P2d 531 (1990). Claimant could have, but did not, challenge the denial of her claim for medical services for her back condition. The denial became final for the purposes of claim preclusion when she did not timely request a hearing. ORS 656.319; *Drews v. EBI Companies, supra,* 310 Or at 149.

**117 Or App 245>** Claimant also argues that the denial was vague and that no substantial evidence supports the Board's ruling that she had no right to medical services unless she proved that her condition had changed. The March, 1987, denial letter reads, in part:

> "Your attorney has recently made an application for increased compensation because of an aggravation claim. It is our position that there is no worsening of your underlying accepted condition and *furthermore, your present problems as treated by Dr. Holbert are not related to the original accepted injury.* Your aggravation claim is hereby denied." (Emphasis supplied.)

The letter refers to medical services provided by Holbert relating to claimant's "present problems. " Claimant does not dispute that, when she filed the claim, she sought payment for medical services only for her back condition. There is substantial evidence to support the Board's finding that employer denied the claim for medical services for the back condition.

Affirmed.

Cite as 117 Or 246 (1992) December 16.1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Esther M. Wasson, Claimant.

Esther M. **WASSON**, *Petitioner,*
v.
**EVANITE FIBER CORP.**, *Respondent.*
(89-22501; CA A71152)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1992.

Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief were Donald M. Hooton and Malagon, Moore, Johnson & Jensen, Eugene.

Paul A. Dakopolos, Salem, argued the cause for respondent. With him on the brief were Robert R. Trethewy and Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed

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**117 Or App 248>** Claimant seeks review of a Workers' Compensation Board order that denied her aggravation claim. We review for substantial evidence and errors of law, ORS 656.298(6); ORS 183.482(7), (8), and affirm.

Claimant sustained a compensable knee injury in 1985. In 1986, a determination order awarded her 30 percent scheduled permanent partial disability. In 1987, she filed claims for depression and for hip and back conditions, but employer denied those claims. The parties entered into a disputed claim settlement (DCS) that increased claimant's PPD to 60 percent and confirmed the denial of the hip and back conditions and the depression.

Claimant now claims that her depression has worsened. The Board found that her depression has worsened since the DCS; however, it ruled that it was not compensable, because it was the same condition that had been denied in the DCS. Under *Proctor v. SAIF*, 68 OrApp 333,335,681 P2d 161 (1984), a worsening is compensable only if the claimant can show that it is a *different* condition from the one that was denied in the DCS. *See also Gilkey v. SAIF*, 113 Or App 314, 832 P2d 1252, *rev den* 314 Or 573 (1992). Claimant's doctor testified that her current psychological condition is the same as was diagnosed in 1987. Substantial evidence supports the Board's finding that the depression was the same.

Claimant also argues that, by not allowing her to relitigate issues settled by the DCS, we are denying her an opportunity to contest an issue that would be a viable subject for an aggravation claim if it had been resolved through litigation. However, the DCS was a final resolution of the compensability dispute concerning her depression. Absent a showing that the present psychological condition is different from the original condition, permitting relitigation would undermine the finality for which employer *and* claimant bargained.

Affirmed.

Cite as 117 Or App 280 (1992) December 23, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Fred H. Jacobson, Claimant.

**PACIFIC POWER & LIGHT**, Petitioner,
v.
FRED H. **JACOBSON**, Respondent.
(90-11363; CA A70655)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 3, 1992.
Craig A. Crispin, Portland, argued the cause for petitioner. With him on the brief were Alan M. Lee and Bullard, Korshoj, Smith & Jernstedt, Portland.
William A. McDaniel, Coos Bay, argued the cause for respondent. With him on the brief were Juli Point and Foss, Whitty, Littlefield & McDaniel, Coos Bay.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed.

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**117 Or App 282>** Claimant works for employer as a lineman representative. He injured his shoulder while eating lunch at a restaurant when the stool on which he was sitting collapsed. Employer seeks review of the Workers' Compensation Board's order holding that the injury is compensable.

The facts are not disputed. Claimant lives in Myrtle Point, which is 9 miles south of employer's main office in Coquille. Claimant drives to Coquille every day to pick up his orders from the main office. He then works in a territory from Coquille to north of Powers. His duties include system maintenance, responding to customer requests, trimming trees, collecting payments on bills and reading meters. He drives a company truck and is paid by the hour. He carries a portable two-way radio in order to maintain contact with employer and, on occasion, radios employer or receives orders from the Coquille office.

Claimant's union contract provides for a one-hour lunch period at noon, during which time he is free to do as he wishes. Unless he is working through his lunch hour on an emergency, he is not paid for that time and does not receive reimbursement for his expenses. Because he is usually in the Powers area at lunch time, it is inconvenient for him to drive home for lunch. Claimant occasionally attends meetings of service organizations or civic functions on behalf of employer and, when he does, he is reimbursed for his expenses. Occasionally he radios employer while he is in Powers to let his supervisor know that he is going to lunch, although he is not required to.

Claimant regularly eats at Jack's, a cafe in Powers. On the date of the injury, he drove from his home in Myrtle Point to Coquille, where he received orders to go to Powers to read meters and to carry out other duties. He worked in Powers until lunch time and then went to Jack's to eat. The stool on which he was sitting collapsed, and he fell to the floor, injuring his right shoulder. He filed a claim for that injury, which employer denied. The referee and the Board held that it was compensable.

The Board reasoned that the relationship between the injury and the employment was sufficient under the **<117 Or App 282/283>** unified test in *Rogers v. SAIF*, 289 Or 633, 642, 616 P2d 485 (1980), to render the injury compensable. In aid of that determination, the Board referred to the factors identified in *Jordan v. Western Electric*, 1 Or App 441, 463 P2d 598 (1970), and later in *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 575, 703 P2d 255, *rev den* 300 Or 249 (1985), as being significant in deciding whether claimant was acting in the course of his employment.[1]

The Board also cited *Halfman v. SAIF*, 49 Or App 23, 618 P2d 1294 (1980), in which we held that a worker who was injured by an automobile while crossing a city street to use a restroom and refreshment facilities during a paid break was entitled to compensation. In that case, we also considered the factors identified in *Jordan*. We found that use of neighborhood facilities was clearly contemplated by the employer and that it was of benefit to the employer, because the availability of those facilities

relieved it of the burden of providing them. We held that, when an employer has created the need for the employee to go off the premises for personal comfort activities, the risk of injury while the worker is engaging in those activities is an ordinary risk of, and is incidental to, the employment. Because the employer had no restroom facilities, we held that the fact that the injury occurred off the employer's premises was not significant.

The Board concluded that this case is similar to *Halfman* and that, by requiring claimant to travel away from its premises on a daily basis, employer anticipated the risk of an injury that might occur off premises in the context of ordinary comfort activities, such as eating lunch. Thus, the **<117 Or App 283/284>** Board relied on a factor that ordinarily weighs against compensability, that the injury occurred off of employer's premises, to hold the claim compensable. That is, it held that, when the nature of the work *requires* the employee to eat lunch off the premises, injuries that occur during lunch are anticipated risks of the employment and are in the course of the employment.[2]

In the light of the Supreme Court's opinion in *SAIF v. Reel*, 303 Or 210, 216, 735 P2d 364 (1987), the test for determining whether an off-the-job injury is compensable is whether the activity causing the injury is an "integral" part of the worker's employment. The court said that the problem is "best resolved by examining the contractual relationship of the parties to determine if the claimant's injury 'arose out of and in the course of' his employment." 303 Or at 216. Applying that standard, and given the undisputed facts, the Board could only have concluded that claimant was not in the course of his employment at the time of his injury.

The fact that claimant was required to eat away from employer's premises does not, in itself, mean that eating lunch was part of his employment. The terms of the employment agreement are controlling: Under his union contract, claimant's one hour lunch break was unpaid, and he was free to do whatever he chose to do during that time. He could go home, go out for lunch, run errands, go fishing or, even, roller skating. Employer exercised no control over claimant while he was on his lunch break. Therefore, activities carried on during the break must be characterized as purely personal and outside the course of his employment.[3]

Reversed.

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[1] The factors are:

"a) Whether the activity was for the benefit of the employer[;]

"b) Whether the activity was contemplated by the employer and employee either at the time of hiring or later[;]

"c) Whether the activity was an ordinary risk of, and incidental to, the employment[;]

"d) Whether the employee was paid for the activity[;]

"e) Whether the activity was on the employer's premises[;]

"f) Whether the activity was directed by or acquiesced in by the employer[;]

"g) Whether the employee was on a personal mission of his own[.]" Jordan v. Western Electric, supra, 1 Or App at 443. (Citations omitted.)

[2] We note that, in *Halfman*, we found on *de novo* review that the claimant was on a paid break at the time of his injury. 49 Or App at 30. The same was true in *Mellis*. 74 Or App at 574.

[3] We reject claimant's contention that the Board should be affirmed, because he was a "travelling employee." The "travelling employee" concept is applicable when the employee is required to travel *overnight* away from home and the employer's premises. See 1A Larson, *Workmen's Compensation Law*, 5-275, 25.00 (1992).

Cite as 117 Or App 285 (1992) December 23, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Merlyn G. Johnsen, Claimant.

MERLYN G. **JOHNSEN**, Petitioner,
v.
**BEACON ELECTRIC/HAMILTON ELECTRIC** and SAIF CORPORATION, Respondents.
(89-17994; CA A70709)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 1, 1992.
David C. Force, Salem, argued the cause for petitioner. With him on the brief was Vick & Gutzler, Salem.
Julie K. Bolt, Special Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

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**117 Or App 287>** Claimant seeks review of an order of the Workers' Compensation Board order holding that his occupational disease claim is precluded by an earlier determination denying an earlier claim. We agree with the Board and affirm.

The Board found that claimant has been employed as an electrician by the same employer since the 1950's, when employer's name was Hamilton Electric Company. It also found that, some time before 1983, Hamilton changed its name to Beacon Electric. In 1983, claimant filed an occupational disease claim against Hamilton, contending that exposure to asbestos in the 1950's and 1960's had caused a compensable lung condition. The claim was denied by SAIF. The denial was upheld by the referee and the Board and ultimately by this court on *de novo* review, on the basis that claimant's lung condition was not symptomatic and required only annual medical monitoring, not treatment. *Johnsen v. Hamilton Electric*, 90 Or App 161, 165, 751 P2d 246 (1988).

In this claim against Beacon, filed in 1988, claimant alleges that he was exposed to asbestos on the job in 1984, while the first claim was pending. He assigns error to the Board's holding that the 1988 claim is barred. First, he argues that the evidence does not support the Board's statement that Beacon and Hamilton are the same employer.

Whether or not the employers are different, the claim is barred by issue preclusion if the exposures and conditions are the same as those considered in the earlier claim. In our *de novo* review of the earlier claim, we reviewed medical reports from 1986 that presumably had considered claimant's 1984 exposure to asbestos, and we found that he did not have a compensable condition. The Board found that the condition for which claimant now seeks compensation was caused by claimant's employment exposures to asbestos in the 1950's and 1960's and that it is the same condition and exposures for which he sought compensation in the first claim. Substantial evidence supports those findings. Claimant does not contend that his condition is any different now than it was at the time of the hearing on the first claim. We agree with the Board that the claim is barred.

**117 Or App 288>** We reject claimant's contention that changes in the occupational disease law necessitate a different analysis of this claim than was made on the 1983 claim.

Affirmed.

Cite as 117 Or App 293 (1992) December 23, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Judy R. Hicks, Claimant.

JUDY R. **HICKS**, Petitioner,
v.
**SPECTRA PHYSICS** and CIGNA INSURANCE COMPANY, Respondents.
(WCB 90-22539; CA A73639)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 7, 1992.
Karsten H. Rasmussen, Eugene, argued the cause and filed the brief for petitioner.
Craig Staples, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

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**117 Or App 295>** Claimant seeks review of a Workers' Compensation Board order holding that her injury is not compensable. We affirm.

Claimant suffered a compensable injury in September, 1989. When she was returning from a treatment for the injury in October, she was injured in an automobile accident. Employer denied her claim for the October injury, and the referee and the Board upheld the denial.

Claimant argues that the injuries sustained in the October accident are compensable, because they are work-related. Under our decision in *Fenton v. SAIF*, 87 Or App 78, 741 P2d 517, *rev den* 304 Or 311 (1987), she would be correct:

> "[W]hen a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury is also compensable[, because it is] a direct and natural consequence of her compensable injury." 87 Or App at 83.

Employer argues, and the Board agreed, that the 1990 amendments to the workers' compensation law legislatively overruled *Fenton*. The Board concluded that, under ORS 656.005(7)(a)(A), as amended in 1990, her claim is for a consequence of a compensable injury, which is not compensable because the compensable injury was not the major contributing cause of the consequential condition. The statute provides:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, 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 a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

The Board said:

> "It is undisputed that claimant's injuries arose not from the compensable September 1989 industrial accident, but **<117 Or App 295/296>** rather as a consequence of an October 1989 motor vehicle collision while returning home from physical therapy for the compensable condition. * * * As claimant's original industrial injury was not the major contributing cause of her consequential headaches and musculoligamentous conditions, her claim is not compensable."

The issue is whether the injuries that claimant suffered as a result of the automobile accident are a "consequence of a compensable injury" and therefore subject to the major contributing cause test of ORS 656.005(7)(a)(A). We first considered the consequential condition language in *Albany General Hospital v. Gasperino*, 113 Or App 411, 833 P2d 1292 (1992). The issue was whether a condition that arose directly but belatedly from the original injury was subject to the major contributing cause standard. We concluded, on the basis of legislative history, that it was not:

> "The reference in ORS 656.005(7)(a)(A) to 'consequence' of a compensable injury is ambiguous. * * * The major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every *industrial injury* claim. * * * The distinction is between a condition or need for treatment that is caused by the industrial accident, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury*. It is the latter that must meet the major contributing cause test." 113 Or App at 414. (Footnote omitted; emphasis in original.)

Now, we are faced with a different question: Does the phrase in ORS 656.005(7)(a)(A), "consequence of a compensable injury," include injuries that are the result of activities that would not have been undertaken but for the compensable injury? As in *Gasperino*, we look to legislative history for the answer. Representative Mannix explained the changes in the law:

> "We keep the standard for compensability of an industrial injury itself as whether [the] work is a material contributing cause of a given condition, but as to consequential damages we do set up a major contributing cause analysis. And what [that] means is if you have a broken arm, that's industrial. And you're crossing the street on the way to see your doctor, and the doctor's office is right over there, and you're headed across the street, and a car runs you down. Under current **<117 Or App 296/297>** law, whatever happened to you in that street is included in workers' comp[ensation]. * * * [It's] considered a consequence of your industrial injury. You got hurt on the way to the doctor. Requiring major contributing cause means that no, being run down crossing the street on the way to the doctor is not covered. That's, to me, the most succinct example of the kind of change we are making there." House Special Session, May 7, 1990, Tape 2, Side A.

Senator Kitzhaber also explained that the major contributing cause standard would apply "for things that you brought into the workplace *or injuries that occur subsequent to the compensable injury* * * *." Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 26, Side A at 150. (Emphasis supplied.)

Those explanations convince us that the legislature intended to overrule *Fenton v. SAIF, supra.* Under ORS 656.005(7)(a)(A), *any* injury or condition that is not *directly* related to the industrial accident is compensable *only if* the major contributing cause is the compensable injury. Accordingly, the Board applied the correct legal standard.

Affirmed.

Cite as 117 Or App 409 (1992) December 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bahman M. Nazari, Claimant.

**TEKTRONIX, INC.**, Petitioner,
v.
BAHMAN M. **NAZARI**, Respondent.
(90-11477; CA A72401)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 15, 1992.
Barbara A. Brainard, Portland, argued the cause for petitioner. With her on the brief was Stoel Rives Boley Jones & Grey, Portland.
Robert Wollheim, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun & Green, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

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**117 Or App 411>** Employer seeks review of an order of the Workers' Compensation Board setting aside its denial of claimant's low back injury claim. Although we agree with the Board's determination that the claim is compensable, we do not agree with its analysis and write to explain our understanding of the relevant statute.

Claimant has been diagnosed as suffering from mild degenerative disc disease and backaches associated with lifting at work. On April 4, 1990, he felt a sharp pain in his low back while lifting a stack of circuit boards at work. The next day, he was unable to perform certain work activities. He filed a claim with employer, which was denied. The Board treated claimant's condition as an injury, as opposed to an occupational disease. Employer contends that the Board erred in that determination. Because there is substantial evidence to support the Board's finding that there was a discrete event at work that triggered claimant's current disability, it did not err. However, that does not end the inquiry.

Employer contends that, under the provisions of ORS 656.005(7)(a), *as amended by* Or Laws 1990 (Spec Sess), ch 2, 3, claimant's back condition is not compensable, because the disability and the need for treatment were caused, in *major* part, by claimant's preexisting degenerative disc disease, not by the April 4 incident at work. ORS 656.005(7)(a), as amended, provides, in 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 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.*"

**117 Or App 412>** (Emphasis supplied.)

The definition of the term "compensable injury," in particular the "arising out of" language, encompasses the concept of medical causation, *Rogers v. SAIF*, 289 Or 633, 641, 616 P2d 485 (1980), the test ordinarily being whether events at work were a *material* contributing cause of the injury. *See Olson v. State Ind. Acc. Com.*, 222 Or 407, 352 P2d 1096 (1960); *Destael v. Nicolai Co.*, 80 Or App 596, 723 P2d 348 (1986).

A majority of the Board, sitting *in banc*, reasoned that the term "compensable injury," as used in ORS 656.005(7)(a)(B), encompasses the *material* contributing cause test of medical causation. It limited

the application of subparagraph (B) to claims in which it has been determined that the injury is "compensable," *i.e.*, that the work was a *material* contributing cause of the injury. It then reasoned that if, in the *processing* of a "compensable injury," it is determined that the compensable injury "combines with a preexisting disease or condition to cause or prolong disability or need for treatment," the resulting condition is compensable only to the extent that the compensable injury "is and remains the *major* contributing cause of the disability or need for treatment." (Emphasis supplied.)

We do not believe that the legislature intended the two-step process adopted by the Board. If the Board were correct, an employer would be required to accept a claim for which no benefits are due. ORS 656.005(7)(a)(B) uses the term "compensable" to define what is compensable, creating a certain incongruity within that subparagraph. Read in its entirety, however, it is clear that the legislature intended ORS 656.005(7)(a) to define a compensable injury as an injury arising out of and in the course of the employment, subject to the two "limitations" stated in subparagraphs (A) and (B). When the injury for which compensation is sought is the consequence of a compensable injury, ORS 656.005(7)(a)(A), the consequential injury is compensable *only if* the first injury is the *major* contributing cause of the consequential injury. *Albany General Hospital v. Gasperino*, 113 Or App 411, 833 P2d 1292 (1992). Likewise, under ORS 656.005(7)(a)(B), when a work-related injury combines with a preexisting condition to cause disability or a need for **<117 Or App 412/413>** treatment, the work-related injury is compensable *only if* it is the *major* contributing cause of the disability or need for treatment. Claimant's work-related injury combines with his preexisting degenerative condition and is compensable only if it is the major contributing cause of his disability and the need for treatment.

The Board found that claimant's injury is the major contributing cause of his disability and the need for treatment; accordingly, its incorrect analysis of the statute did not affect its result, if there is substantial evidence to support that finding. There is, and the Board did not err in concluding that the claim is compensable.

Affirmed.

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Cite as 117 Or App 455 (1992) December 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Thomas E. Edison, Claimant.

**SAIF CORPORATION** and JUDICIAL DEPARTMENT, Petitioners,
v.
THOMAS E. **EDISON**, Respondent.
(90-12890; CA A73734)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 30, 1992.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Kevin Keaney, Portland, argued the cause for respondent. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Buttler, Presiding Judge, and Richardson and De Muniz, Judges.

BUTTLER, P.J.

Reversed and remanded for reconsideration.

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**117 Or App 457>** Employer seeks review of an order of the Workers' Compensation Board holding that claimant's injury claim for a stroke is compensable, contending that the request for hearing was untimely or, if timely, that the Board applied an incorrect standard of proof.

Claimant is an Oregon circuit court judge.[1] He suffered a stroke one day after conducting a stressful telephone conference with an attorney. The record shows that he also suffered from a preexisting cardiovascular condition. He filed a claim for compensation, which employer denied by

[1] No question is raised as to whether elected officials are subject workers.

letter mailed on April 16, 1990. Claimant received the letter on April 17, 1990. The 60th day after the mailing of the letter was June 15, 1990. The 60th day after claimant's receipt of the letter was June 16, 1990, a Saturday. Claimant filed his request for hearing on Monday, June 18, 1990.

Until 1990, ORS 656.262(8) provided:

> "If an insurer * * * denies a claim for compensation, written notice of such denial * * * shall be given to the claimant. * * * *The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial pursuant to ORS 656.319.*" (Emphasis supplied.)

ORS 656.319(1)(a) provides:

> "A request for hearing is filed not later than the 60th day after the claimant was *notified* of the denial." (Emphasis supplied.)

A potential conflict existed in the statutes as to whether a claimant had 60 days from the date of mailing of the denial, as provided in ORS 656.262(8), or 60 days from the date of receipt of notice of the denial, as suggested in ORS 656.319(1)(a). In *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), the Supreme Court reconciled the two statutes by holding that "mailing" as used in ORS 656.262(8) (then numbered ORS 656.262(6)) equals "notice" as used in ORS 656.319(1)(a), concluding that, with limited exceptions, a claimant had 60 days after mailing of the denial to request a hearing.

**117 Or App 458>** In 1990, the legislature amended ORS 656.262(8) by changing the emphasized language to read: "The worker may request a hearing *pursuant* to ORS 656.319." (Emphasis supplied.) The amended version is applicable here. Claimant contends that, by deleting the reference to mailing from ORS 656.262(8) but retaining the reference to notice in ORS 656.319(1), the legislature intended to overrule *Norton* and to give the claimant 60 days from the date of *receipt* of actual or constructive notice of the denial within which to file a request for hearing. That is not a necessary reading of the statutes. ORS 656.319 still provides, as it did at the time of the *Norton* decision, that the claimant must request a hearing not later than 60 days after notification of the denial. *Norton* provides that notification occurs when the denial is mailed. The change in the statute does not necessarily show an intention to change that rule, although it is questionable whether the legislature would have amended the statute unless it intended the change to make a difference.

The ambiguity created by the amendment is resolved by reference to the legislative history, which shows that the legislature deleted the mailing language from ORS 656.262(8) in order to make notification contingent on actual or constructive receipt of the denial. Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 40.

The 60th day for filing a request for hearing was Saturday, June 16, 1990. Because the 60th day fell on a Saturday, claimant had until the following Monday within which to file a claim. *See* ORS 174.120; ORCP 10A. Claimant's request for hearing, filed on Monday, June 18, was timely.

We conclude, however, that the Board did not consider this claim under the appropriate statute. ORS 656.005(7)(a) provides, in part:

> "(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.
>
> "(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 **<117 Or App 458/459)** only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

The referee considered only subparagraph (A) and concluded that it is inapplicable. Clearly, it is not applicable; claimant's injury is not a consequence of a preexisting compensable injury. Although employer argued that subparagraph (B) was applicable, the referee did not consider it. The Board adopted the referee's findings and decision on this question without discussion. Given the record and, because employer has argued all along that the claim should be considered under ORS 656.005(7)(a)(B), the case must be remanded for reconsideration. *See Tektronix, Inc. v. Nazari*, 117 Or App 409, ___ P2d ___ (1992).

Reversed and remanded for reconsideration.

Cite as 117 Or App 490 (1992) December 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Walter Jones, Jr., Claimant.

WALTER **JONES**, JR., Petitioner,
v.
**SHERRELL CHEVROLET** and SAIF CORPORATION, Respondents.
(90-07999; CA A69911)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 28, 1992.
Donald M. Hooton, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.
Michael O. Whitty, Special 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 Deits and Durham, Judges.
DEITS, J.
Reversed and remanded for reconsideration.

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**117 Or App 492>** Claimant seeks review of an order of the Worker's Compensation Board holding that he is no longer permanently and totally disabled under ORS 656.206(1)(a).[1] Claimant argues that employer did not sustain its burden to prove that he is able to maintain gainful and suitable employment. We remand for reconsideration in light of *Tee v. Albertson's, Inc.*, 314 Or 633, 842 P2d 374 (1992).

Claimant's compensable injuries to the head, neck, low back and legs occurred in 1962, as the result of an accident while he was working as a car salesman. He was declared permanently and totally disabled by a stipulated order in 1965. There is little evidence regarding his medical condition or work experience between 1965 and the late 1970's. However, medical reports indicate that he began working for U.S. West selling directory advertising some time after 1980. He maintained that position until he had open heart surgery in late 1989.

In 1989, pursuant to ORS 656.206(5),[2] employer requested a reevaluation of claimant's permanent total disability award. The reevaluation determined that he is no longer permanently and totally disabled. Claimant requested a hearing. The referee found that his position as a sales representative for U.S. West was regular part-time work constituting gainful and suitable employment that precluded an award of permanent and total disability. The Board affirmed and adopted the referee's order.

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[1] ORS 656.206(1)(a) provides:

"'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

[2] ORS 656.206(5) provides:

"Each insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker is currently permanently incapacitated from regularly performing work at a gainful and suitable occupation. Reexamination shall be conducted every two years or at such other more frequent interval as the director may prescribe. Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary or the director may require. The insurer shall forward to the director the results of each reexamination."

**117 Or App 493>** When an employer seeks to terminate or modify a permanent total disability award, it has the burden to prove that the claimant presently is able to engage in a gainful and suitable occupation. *See Harris v. SAIF*, 292 Or 683, 690, 642 P2d 1147 (1982). Claimant argues that the evidence is insufficient, because there is no evidence in the record of the duration or character of his employment. In *Tee v. Albertsons Inc., supra*, the claimant argued that, although she was capable of part-time work, she was entitled to a permanent total disability award because of the significant reduction in her earnings. She contended that the occupation that she was capable of performing part time did not constitute a "gainful occupation" under ORS 656.206(1)(a). The Supreme Court concluded that the term "gainful occupation" used in that statute means profitable remuneration. 314 Or at 643. The court then remanded the case for reconsideration in the light of its opinion, because "the Board is the appropriate body to apply the meaning of 'gainful occupation' under the facts of this case in performing its fact-finding function * * *." 314 Or at 643. Because this case involves the same issue as *Tee v. Albertsons, Inc., supra*, we remand it to the Board for reconsideration in light of that opinion.

Claimant also argues that the referee found that the vocational expert misrepresented his job qualifications and, therefore, the referee's and the Board's reliance on that evidence was error. Because this issue is likely to arise on remand, we address it. The vocational expert's report showed that there is a labor market in advertising sales that claimant would be qualified to enter. The referee noted that the expert's report did make claimant appear to be qualified for highly competitive jobs, such as jobs with television stations, for which he was not in fact qualified. However, the referee did not find that the remainder of the report or its ultimate conclusion that there was some work available for claimant was inaccurate. The referee said:

> "*SAIF also has in evidence vocational materials suggesting that there is a substantial labor market for claimant for advertising sales.* I must note that these same vocational materials, in attempting to fix claimant's employability specifically, misrepresent his educational background and job skills to make him appear employable in connection with **<117 Or App 493/494>** highly competitive jobs such as those with television stations." (Emphasis supplied.)

The Board did not err in relying on the vocational expert's report.

Reversed and remanded for reconsideration.

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Cite as 117 Or App 515 (1992) December 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rinaldo F. Sinclair, Claimant.

RINALDO F. **SINCLAIR**, Petitioner,
v.
**CHAMPION INTERNATIONAL CORP.**, Respondent.
(86-09427; CA A70778)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 8, 1992.
Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Richard T. Kropp and Emmons, Kropp, Kryger, Alexander & Egan, P.C., Albany.
Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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**117 Or App 517>** Claimant seeks review of a Worker's Compensation Board order that held that he is not entitled to permanent total disability (PTD) benefits. We review for substantial evidence and errors of law, ORS 656.298(6); ORS 183.482(7), (8), and affirm.

Claimant compensably injured his back on March 12, 1981, while driving employer's jitney. He also suffered psychological problems due to the injury. In 1984, after failing to complete vocational rehabilitation, he was awarded 50 percent unscheduled permanent partial disability (PPD). In 1987, he filed an aggravation claim, which employer denied. On January 24, 1990, the Board awarded claimant PTD, effective March 28, 1986. On review, we reversed and remanded because, although substantial evidence supported the Board's finding that it would be futile for claimant to seek work, the Board failed to determine whether he was willing to work. *Champion International v. Sinclair,* 106 Or App 423, 807 P2d 345 (1991). On remand, the Board found that claimant had not established his willingness to work and, therefore, was not entitled to receive PTD benefits. Claimant assigns error to that determination.

ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

In *SAIF v. Stephen,* 308 Or 41, 48, 774 P2d 1103 (1989), the Supreme Court held that, to award PTD, the Board must find that, "but for the compensable injury, the claimant would have returned to work."

The Board found that claimant lacked motivation to return to work and exhibited negativity during vocational rehabilitation attempts. The vocational counselor who worked with him in 1982 and 1983 observed his hostility toward his former employer, his distrust of doctors and his conviction that returning to work was not an option for him. His treating physician felt that he did not "seem very motivated" toward rehabilitation. Those observations occurred before the worsening of claimant's psychological condition. **<117 Or App 517/518>** The Board found that there was no evidence regarding his willingness to work more recent than the vocational and medical reports noted above.

Claimant argues that the Board also found that his worsened psychological condition was a compensable part of his claim and that it was partially responsible for his resistance to rehabilitation efforts and his exaggerated physical complaints. He argues that those findings are inconsistent with the Board's ultimate conclusion. He also contends that minimal efforts to seek work are sufficient, if any greater effort would have been futile. *See SAIF v. Simpson,* 88 Or App 638, 641, 746 P2d 257 (1987), *rev den* 305 Or 273 (1988).

The Board is responsible for deciding whether claimant is willing to work but for his compensable condition. Claimant had the burden to prove that he had sought work or that he would have been willing to work but for the compensable injury, and he is not relieved of that burden when seeking work would be futile. *SAIF v. Stephen, supra,* 308 Or at 48. The Board determined that, even though it would have been futile for claimant to seek work, he failed to prove that he was willing to work. His evidence that his psychological condition was part of the cause of his resistance to rehabilitation, does not prove that he was willing to work but for the condition.

We consider the Board's findings in the light of claimant's burden of proof and conclude that the findings are not inconsistent. The record contains no evidence that, but for his worsened psychological condition, he would have been willing to work. The Board's finding is supported by substantial evidence. *See SAIF v. Stephen, supra.*

Affirmed.

Cite as 117 Or App 596 (1993) January 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rosalie S. Drews, Claimant.

**SAIF CORPORATION** and MARQUIS HOMES, INC., Petitioners,
v.
ROSALIE S. **DREWS** and WAUSAU INSURANCE COMPANIES, Respondents.
(90-05597, 90-15186; CA A73419)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 4, 1992.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Karsten Rasmussen, Eugene, argued the cause for respondent Rosalie S. Drews. On the brief were Eveleen Henry, Allison Tyler and Rasmussen & Henry, Eugene.
David O. Horne, Beaverton, filed the brief for respondent Wausau Insurance Companies.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Affirmed.
*Leeson, J., *vice* Buttler, J., retired.

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**117 Or App 598>** SAIF petitions for review of an order of the Workers' Compensation Board holding it responsible for claimant's low back condition. We affirm.

In 1985, while employed by Wausau Insurance Companies' insured, claimant injured her low back and left leg on the job. Wausau accepted the claim. The injury was described as a "sprain, strain of low back, herniated."

Claimant began to work for SAIF's insured in December, 1989. On December 26, 1989, claimant tripped and fell at work and hurt her low back and left leg. An MRI showed a "mild posterior central disc bulging at L5-S1, slightly more prominent than on a previous study of 9 September 1986," and "central posterior annular bulging at L4-5 which also appears slightly more prominent than on the previous study." Dr. Nagel was of the opinion that claimant's symptoms are due to the second injury.

In June, 1990, claimant's attorney sent Wausau a notice of claim. Wausau declined to reopen the claim, on the ground that claimant had suffered a new low back injury in 1989 while employed by SAIF's insured; therefore, it was no longer responsible for the condition.

SAIF contends that ORS 656.005(7)(a)(B) is applicable and requires Wausau to show that the 1989 injury is the major contributing cause of the disability and need for treatment. The Board held that that statute is not applicable in the context of assigning responsibility. We agree. ORS 656.005(7)(a) provides, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, 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 a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the **<117 Or App 598/599>** major contributing cause of the disability or need for treatment."

ORS 656.005(7)(a)(B) defines what is compensable when a work-related injury combines with a preexisting noncompensable disease or condition to cause or prolong disability or a need for treatment. *See Tektronix, Inc. v. Nazari*, 117 Or App 409, ___ P2d ___ (1992). We agree with the Board that subparagraph (B) is not intended to apply in the context of assigning responsibility among successive employers for multiple compensable injuries.

In 1990, the legislature enacted ORS 656.308(1), which provides:

> "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."

The Board explained its understanding of the statute:

> "We have interpreted the amended law to mean that, 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, Wausau, as the last carrier against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, Wausau has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for SAIF's insured.
>
> "In order to prove a new compensable injury, Wausau must show that the 1989 injury is a material contributing cause of disability or need for treatment. *See Mark N. Wiedle*, 43 Van Natta 855 (1991)."

The Board held that Wausau had met that burden and assigned responsibility for the condition to SAIF.

**117 Or App 600>** We agree with the Board's analysis. Wausau, as the insurer with the most recent accepted claim, has the burden of proving that the 1989 injury is a *material* contributing cause of claimant's disability or need for treatment. The Board found that Wausau had made that showing, and there is substantial evidence to support the finding.

Affirmed.

Cite as 117 Or App 601 (1993) January 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sam D. Ferguson, Claimant.

**ROSEBURG FOREST PRODUCTS**, Petitioner,
v.
SAM D. **FERGUSON**, Respondent.
(WCB 91-01766; CA A73719)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 14, 1992.
Adam T. Stamper, Medford, argued the cause for petitioner. With him on the brief was Cowling & Heysell, Medford.
David Morrison, Roseburg, argued the cause for respondent. With him on the brief was Aller & Morrison, Roseburg.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Affirmed.
*Leeson, J., *vice* Buttler, J., retired.

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**117 Or App 603>** Employer seeks review of an order of the Workers' Compensation Board holding that emergency room treatment of claimant's surgical incision resulting from compensable carpal tunnel surgery is compensable.

Activities of claimant's employment caused carpal tunnel syndrome, which employer accepted as compensable and for which claimant received surgery. One week after the carpal tunnel surgery, claimant fell at home and his sutures came out. He went to the emergency room for repair of the sutures. Employer refused to pay the emergency room bill, contending that the fall at home, rather than the compensable carpal tunnel syndrome, was the major contributing cause of the need for treatment.

ORS 656.005(7)(a) provides, in 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 a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

Employer argues that the emergency treatment must be considered under ORS 656.005(7)(a)(A) as a "consequence of a compensable injury," and that it is not compensable unless the carpal tunnel syndrome is the major contributing cause of the need for emergency room care.

The Board reasoned that the fall at home did not give rise to a new "injury," as such, and that the provisions of ORS 656.005(7)(a)(A) therefore are not applicable. It held that the services are properly characterized as medical services "for conditions resulting from the injury" under ORS 656.245, and that claimant established compensability by showing that the emergency care bears a material relationship to the healing of the compensable carpal tunnel surgery. We agree.

**117 Or App 604>** When claimant fell at home and damaged his sutures, he suffered no new "injury" or condition different from the carpal tunnel syndrome. The emergency room treatment necessary to resuture the wound is compensable under ORS 656.245 as continued medical treatment bearing a material relationship to the compensable carpal tunnel syndrome.

Affirmed.

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Cite as 117 Or App 605 (1993) January 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Complying Status of Swift & McCormick Metal Processors Association, Inc., and In the Matter of the Compensation of William L. Durbin, Claimant.

**SWIFT & McCORMICK METAL PROCESSORS ASSOCIATION**, INC., Petitioner,
v.
WILLIAM L. **DURBIN** and SAIF CORPORATION, Respondents.
(90-15703, 90-12311; CA A70594)

Judicial Review from Department of Insurance and Finance.
Argued and submitted May 15, 1992.
Denise S. Frisbee, Redmond, argued the cause for petitioner. With her on the brief were Craig P. Emerson and Bryant, Emerson & Fitch, Redmond.
Julie K. Bolt, Special Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With her on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
No appearance for respondent William L. Durbin.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DEITS, J.
Reversed and remanded for reconsideration.

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**117 Or App 607>** Employer seeks review of a Department of Insurance and Finance (DIF) order[1] holding that it was a noncomplying employer from January 1 to March 31, 1990. ORS 656.740(4). We reverse and remand.

Employer had workers' compensation insurance coverage with SAIF beginning January 18, 1989. On November 3, 1989, SAIF sent employer notice that coverage would be cancelled effective December 31, 1989. Employer began looking for other coverage. In late December, SAIF sent employer a payroll report form for the quarterly period ending December 31. That report mistakenly showed that the policy period ran from January 18, 1989, to March 31, 1990. Because of that, employer stopped looking for other insurance and returned the report to SAIF in January with the required payment. Nonetheless, SAIF canceled employer's coverage, effective December 31, pursuant to its earlier notice. Employer obtained coverage through the Assigned Risk Pool, effective March 16, 1990. However, it had no coverage from January 1 to March 15. On March 9, one of its employees was injured on the job. DIF issued an order holding that employer was a subject and noncomplying employer for the period in question and that SAIF was not estopped from denying coverage. Employer seeks review of DIF's order.

The order set out the elements of equitable estoppel as

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[1] Because this case involves only employer's status as a noncomplying employer, claimant's right to compensation is not at issue, and he made no appearance below.

> "(1) a false representation; (2) made with knowledge of the facts; (3) where the other party is ignorant of the truth; (4) made with the intention that the other party will rely upon it; and (5) the other party must be induced to act upon the false representation."

DIF concluded that

> "SAIF's payroll report form falsely represented that the policy was in effect until March 31, 1990. That false representation was made by SAIF with the knowledge that it was, in fact, canceling coverage at midnight December 31, 1989. **<117 Or App 607/608>** The employer was induced to act upon the false representation and delayed obtaining other coverage."

DIF held, nonetheless, that SAIF was not estopped from denying coverage, because employer failed to prove either that it did not know that coverage was canceled as of December 31 or that SAIF intended that employer rely on the policy dates in the payroll report:

> "The employer, however, has failed to establish the remaining elements necessary to invoke the doctrine of equitable estoppel. The evidence will not support a finding by a preponderance that the employer was ignorant of the truth. SAIF did not intend that the employer rely upon the policy dates given in the payroll report form.
>
> "The employer also argues that SAIF should be estopped to deny coverage because it did not refund the employer's premium deposit until April 4, 1990. The employer did not, in fact, rely on that action. Instead, the owners of the business decided not to obtain insurance because of their mistaken belief that their policy period continued through March 31, 1990."

Employer first argues that DIF's finding that it was not ignorant of the truth is not supported by substantial evidence and is inconsistent with other findings in DIF's order. Specifically, employer points to the finding that it had a mistaken belief that the policy period extended through March 31, 1990. We agree that the findings are inconsistent. If, in fact, employer believed that the policy period extended to March 31, it was ignorant of the truth. SAIF argues that the findings are not inconsistent, because what DIF really meant was that employer's belief that its coverage was extended was unreasonable. However, that is not what the order says.

Employer also argues that DIF erred as a matter of law in setting out the elements of equitable estoppel. In particular, employer argues that proof of intent to mislead is not a prerequisite to estoppel. Affirmative misconduct is not a prerequisite to the application of equitable estoppel. Rather, the doctrine may be applied when conduct is "misleading," even if it is innocent. In *Pilgrim Turkey Packers v. Dept. of Rev.*, 261 Or 305, 310, 493 P2d 1372 (1972), the court applied equitable estoppel when the agency's action was not intended **<117 Or App 608/609>** to be misleading, but was ambiguous enough to mislead a reasonable person. *See Employment Div. v. Western Graphics Corp.*, 76 Or App 608, 614, 710 P2d 788 (1985). DIF applied the wrong standard. *See Meier & Frank Co. v. Smith-Sanders*, 115 Or App 159, 163, 836 P2d 1359 (1992).

Reversed and remanded for reconsideration.

Cite as 118 Or App 15 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Peggy A. Dawes, Claimant.

PEGGY A. **DAWES**, Petitioner,
v.
NEVI I. **SUMMERS** and EBI COMPANIES, Respondents.
(89-14499; CA A68220)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1991.
Darris K. Rowell, Salem, argued the cause for petitioner. With him on the brief was Olson, Rowell & Walsh, Salem.
Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.
Durham, J., concurring in part, dissenting in part.

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**118 Or App 17>** Claimant seeks review of an order of the Workers' Compensation Board. She assigns as error the Board's denial of a penalty and attorney fees for employer's failure to pay temporary disability compensation, its allowance of recovery of an overpayment against future awards of permanent disability and its finding that claimant had been terminated for reasons unrelated to her injury. We affirm.

Claimant was released to return to work after sustaining a compensable injury. She returned to her job as a housekeeper and cook on April 1, 1987. Four days later, she was terminated. She had failed to report to work for two of her scheduled days and had reported late the other two days. She never contacted employer to tell her of the situation, but instead had her son call one of the days she was absent to announce that she would not come to work that day.[1] She did not seek other work. Employer unilaterally terminated temporary disability benefits on April 27, 1987. A determination order dated June 28, 1989, awarded claimant temporary disability, stating in part:

> "The department orders you entitled to additional compensation for temporary disability, less time worked, as follows:
>
> "For temporary total disability from Sep [sic] 5, 1984 through May 7, 1986, per stipulation and order dated Feb 26, 1986 and Dec 6, 1988, and for temporary total from May 8, 1986 through May 16, 1989.
>
> "* * * * *
>
> "Deduction of overpaid temporary disability, if any, from unpaid permanent disability is approved. Your condition was found to be medically stationary on May 16, 1988."

Employer did not pay any temporary disability benefits for the period after claimant was fired. Claimant requested a hearing. She argued that her claim was prematurely closed and sought enforcement of the determination order, seeking temporary disability compensation for April 27, 1987, through May 16, 1989. Employer argued that, **<118 Or App 17/18>** because claimant was terminated for reasons unrelated to her injury, she was not entitled to temporary disability after the date of termination. The referee agreed that claimant was fired because of her failure to report to work and concluded that employer was "not obligated to recommence temporary disability after April 5, 1987." The referee allowed employer an offset for temporary benefits paid after that date.

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[1] The Board made no specific finding as to whether claimant voluntarily left the work force before she was fired. It found that "claimant was released to modified work which she left for reasons unrelated to her compensable condition."

On reconsideration, the referee decided that, even if employer disputed claimant's entitlement to benefits, it was still required to pay in accordance with the determination order until it could successfully contest entitlement, at which time it would be entitled to an offset against future awards. The referee further found that employer's failure to comply with the determination order was unreasonable and assessed a penalty of 25 percent of the compensation owed and unpaid and $400 in fees to claimant's attorney.[2]

Claimant requested Board review, arguing that the referee erred in allowing employer to offset temporary benefits that claimant was found not to be entitled to. Employer also sought review, arguing that the referee had erred in concluding that it was required to pay temporary disability benefits from April 5, 1987, to May 16, 1989, and in assessing a penalty and attorney fees. The Board adopted the conclusions and reasoning of the referee concerning employer's obligation to pay temporary benefits after April 5, 1987, and the award of an offset. However, it reversed the assessment of a penalty and attorney fees, concluding that the language of the determination order, as it pertained to the temporary disability award, was ambiguous. It found that employer "had a legitimate doubt in regards [*sic*] to its duty to pay temporary total disability pursuant to the Determination Order" and that its failure to pay was not unreasonable.

Claimant first assigns error to the Board's refusal to assess a penalty and attorney fees for employer's failure to pay temporary disability for the period after claimant was terminated. Under the applicable laws, penalties and attorney fees were appropriate when an employer unreasonably **<118 Or App 18/19>** delayed or refused to pay compensation.[3] ORS 656.262(10); ORS 656.382(1). However, if an employer's failure to pay is premised on a legitimate doubt as to its liability, its conduct is not unreasonable. *See Emery v. Adjustco*, 82 Or App 101, 107, 727 P2d 622 (1986).

Employer contends that it interpreted the phrase "less time worked" in the portion of the determination order requiring it to pay temporary disability to include the time during which claimant would have continued to work but for her termination. Accordingly, it concluded that the determination order did not require it to pay temporary disability benefits for the time after claimant was fired. Employer concedes that "events have shown that it was incorrect to withhold benefits" but argues that its interpretation of the order was not unreasonable. We agree. Employer should have continued to pay temporary disability and then sought to recover the payments to which claimant was not entitled as offsets against future benefits. Nevertheless, as the Board concluded, the language of the determination order was ambiguous and, therefore, employer's failure to pay was based on a legitimate doubt as to its liability. Denial of penalties and attorney fees was proper.

In her second assignment, claimant contends that the Board erred in determining that she was not entitled to temporary disability benefits for the time after she was terminated from work and in allowing employer an overpayment against future awards of permanent disability. The Board adhered to the referee's holding that, under *Safeway Stores v. Owsley*, 91 Or App 475, 480, 756 P2d 48 (1988), a worker who returns to work and is thereafter terminated for non-claim reasons is not entitled to temporary benefits under ORS 656.212. Claimant argues, however, that that holding is inconsistent with the Board's administrative rules, which she contends should control over the case law.

Claimant points out that OAR 436-60-030(3) provides that an insurer shall pay temporary disability compensation "as is due" in accordance with OAR 436-60-030(1) and **<118 Or App 19/20>** OAR 436-60-030(2).[4] She asserts that, under those rules, an employer must continue to pay temporary

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[2] The referee also found claimant to be medically stationary as of May 16, 1989. The Board adopted this finding, and claimant does not challenge it on review.

[3] The statutes have since been amended. Or Laws 1990, ch 2, 15, 23. *See Oliver v. Norstar Inc.*, 116 Or App 333, 840 P2d 1382 (1992).

[4] At that time, OAR 436-60-030(3) provided:

> "An insurer shall cease paying temporary total disability compensation and commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination."

partial compensation until (1) a physician verifies that the worker is temporarily totally disabled, (2) temporary disability benefits are terminated by a determination order or notice of claim closure or (3) compensation has been paid for two years. OAR 436-60-030(4).[5]

Temporary disability benefits are to replace wages lost because of a compensable injury. *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75, 821 P2d 426 (1991). Here, no wages, in whole or in part, were lost because of claimant's compensable injury. Rather, she was fired for reasons not related to the claim. Therefore, no temporary compensation was "due." *See Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 744 P2d 295 (1987), *rev den* 305 Or 102 (1988). We conclude that the rules that claimant relies on are not inconsistent with the holding in *Safeway Stores v. Owsley, supra*.[6]

Finally, claimant contends that the Board erred in finding that she was terminated for reasons unrelated to her compensable injury. There is substantial evidence in the record to support the Board's finding.

Affirmed.

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[5] OAR 436-60-030(4) at that time provided:

"Temporary partial disability compensation payable pursuant to section (3) shall continue to be paid until:

"(a) The attending physician verifies that the worker cannot continue working and is again temporarily totally disabled;

"(b) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

"(c) The compensation has been paid for two years."

[6] The dissent contends that our holding is based on a misreading of *Owsley* and *Noffsinger*. Despite the dissent's attempts to read them otherwise, both cases hold that a claimant is not entitled to temporary disability benefits when the claimant leaves work for reasons not related to the compensable injury. In fact, claimant here does not assert that *Owsley* and *Noffsinger* hold otherwise. Rather, she argues that the holdings in those cases are inconsistent with the Board's rules.

**118 Or App 21>** **DURHAM, J., concurring in part, dissenting in part.**

The majority holds that, by firing claimant, employer cut off her right to receive temporary disability benefits for the period after the discharge even though she was still partially disabled and losing wages as a result of her injury. The majority reaches that result by making an unwarranted extension of *Safeway Stores v. Owsley*, 91 Or App 475, 756 P2d 48 (1988), and by disregarding ORS 656.212 and Board rules that assure a right to compensation proportionate to the loss of earning power. I dissent from that holding.

The material facts are that, when claimant was fired, she had been released by her doctor to perform only modified, sedentary work, and she was receiving a reduced wage. ORS 656.212 entitled her to temporary partial disability benefits for up to two years:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

OAR 436-60-030 [1] repeated the statutory guarantee:

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[1] OAR 436-60-030 has since been amended in a way that does not affect this case.

"(1) The rate of temporary partial disability compensation due a worker shall be determined by:

"(a) Subtracting the post-injury wage earnings available from any kind of work; from

"(b) The wage earnings from the employment at the time of, and giving rise to, the injury; then

"(c) Dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then

"(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

"(2) If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.

**118 Or App 22>** "(3) *An insurer shall* cease paying temporary total disability compensation and *commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination.*

"(4) *Temporary partial disability compensation payable pursuant to section (3) shall continue to be paid until*:

"(a) The attending physician verifies that the worker cannot continue working and is again temporarily totally disabled:

"(b) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

"(c) *The compensation has been paid for two years.*" (Emphasis supplied.)

Neither the statute nor the rule makes a firing a ground for terminating temporary disability benefits.

The majority relies on *Safeway Stores v. Owsley, supra,* and *Noffsinger v. Yoncalla Timber Products,* 88 Or App 118, 744 P2d 295 (1987), *rev den* 305 Or 102 (1988), but that reliance is misplaced. In *Owsley,* an injured worker returned to part-time work. She received pay increases under a union contract that caused her part-time weekly wage to exceed her pre-injury full-time wage. She was fired for reasons unrelated to her claim and sought temporary partial disability benefits. We rejected the claim because, under OAR 436-60-030(2), "[i]f the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due." *Owsley* says:

"Claimant's weekly wages were more during the period for which she seeks compensation than at the time of the injury. Therefore, she is not entitled to benefits for temporary partial disability. * * *

"We reject claimant's contention that employer was required to begin paying temporary partial disability benefits again after she was fired. *See Noffsinger v. Yoncalla Timber Products,* [*supra*]; *Nix v. SAIF,* 80 Or App 656, 723 P2d 366, *rev den* 302 Or 158 (1986). *Even assuming that claimant's termination did not preclude recovery of benefits for temporary partial disability,* she would have been entitled only to the amount that she could have received on account of her **<118 Or App 22/23>** disability had she not been fired. In this case, that is nothing." 91 Or App at 479. (Emphasis supplied.)

The italicized statement confirms that the disqualification from benefits was not based on the claimant's discharge. The court assumed that the discharge was *not* a disqualifying event. However, the majority erroneously interprets *Owsley* to hold that the claimant was disqualified because she returned to work and was "thereafter terminated for non-claim reasons." 118 Or App at 19. The majority's misreading of Owsley undermines its analysis of this case.

In *Noffsinger*, the injured worker returned to *regular* work and was fired for reasons unrelated to the claim:

> "The evidence establishes that claimant left work at Yoncalla because he was fired, not because he was disabled. He is not precluded from working for any other employer. We conclude that he has not lost wages because of an inability to work as a result of his compensable condition and that, therefore, he is not entitled to temporary disability benefits." 88 Or App at 121.

*Noffsinger* is distinguishable, because here claimant was released to perform only modified work at a reduced wage. Unlike the claimant in *Noffsinger*, she was not capable of returning to regular work. She continued to lose wages due to the injury to the extent that her pre-injury wage exceeded her post-injury reduced wage. *Noffsinger* does not affect her right to compensation for the continuing proportionate loss of earning power attributable to a compensable injury.

The majority compounds its erroneous reading of *Owsley* and *Noffsinger* by misconstruing the phrase "as is due" in OAR 436-60-030(3). Because the majority reads *Owsley* to hold that a discharge cuts off the injured worker's right to compensation, it concludes that no compensation is "due" under the rule. However, the phrase "as is due" in subsection (3) refers to the benefit calculation formula in subsection (1) and the benefit limitation in subsection (2). Even if the phrase were meant to incorporate all conditions that limit a claimant's right to receive benefits, subsection (4) states those conditions; a firing is not among them. The majority does not explain away that inconsistency.

**118 Or App 24>** Finally, the majority's assertion that "no wages, in whole or in part, were lost because of claimant's compensable injury," 118 Or App at 20, ignores the fact that claimant earned a reduced wage at her modified job. She continued to suffer a wage loss due to her injury to the extent that her pay before injury exceeded her reduced wage. She is entitled to compensation for that proportionate loss of earning power.

If employer believed that claimant was no longer disabled, its proper course was to seek closure of the claim under OAR 436-60-030(4)(b) and ORS 656.268, not to unilaterally terminate benefits. The unfortunate result of the majority's decision is that it relieves the employer of the responsibility to follow legislatively preferred claim closure procedures and permits the employer to unilaterally cut off benefits while the worker is partially disabled and suffering a wage loss. I cannot concur with that result.

I concur in the affirmance of the Board's denial of penalties and attorney fees [2] and its finding that claimant was terminated for reasons unrelated to her injury. However, I would reverse the Board's determination that claimant is not entitled to temporary disability benefits after she was terminated and that employer is entitled to an offset for overpayment.

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[2] Employer relies on *Owsley* in contending that, because claimant was fired, its denial was reasonable and did not warrant an order of penalties and attorney fees. The argument is difficult to accept, because *Owsley's* holding turned on the amount of the claimant's post-injury income, not on the fact that she was discharged. However, the Board's ruling is justified, because no case had determined whether the duty to pay compensation under OAR 436-60-030(4) to a worker performing modified work at a reduced wage was affected by a firing.

Cite as 118 Or App 25 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James A. Rouse, Claimant.

JAMES A. **ROUSE**, Petitioner,
v.
**FMC CORP. MARINE-RAIL**, Respondent.
(89-25719; CA A72479)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 18, 1992.
Douglas D. Hagen, Portland, argued the cause and filed the brief for petitioner.
Karen O'Kasey, Portland, argued the cause for respondent. With her on the brief was Schwabe, Williamson & Wyatt, Portland.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DEITS, J.
Reversed and remanded for reconsideration.

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**118 Or App 27>** Claimant seeks review of a Workers' Compensation Board order that held that employer had not accepted claimant's personality disorder as a compensable condition. We reverse.

While working for employer in 1979, claimant sustained a compensable injury to his right knee. He had surgery and returned to work. Determination orders issued in 1980 and 1981 awarding him temporary total disability (TTD) and permanent partial disability (PPD). In early 1982, claimant was examined by several doctors who, in addition to diagnosing orthopedic disorders, also diagnosed depression, a conversion disorder and a pain disorder, all of which were related to his compensable injury. Another determination order of October, 1982, awarded no additional PPD. In response to the 1982 medical reports, employer filed Form 1502 with the Department of Insurance and Finance stating, "Accepting as non-disabling aggravation -- psychiatric problems." On November 3, employer sent claimant's attorney a letter informing him that it had processed Form 1502 and had accepted claimant's "psychiatric treatment."[1] The 1981 determination order was then set aside, and employer reclassified the aggravation claim as disabling.

Claimant received psychiatric treatment from Dr. Watkins from December, 1982, to August, 1983, and employer paid for those treatments. Watkins diagnosed a dysthymic disorder and a mixed personality disorder, the latter of which was not related to claimant's compensable condition.[2]

In June, 1983, claimant injured his right foot after his knee gave out on some stairs. The injury was accepted as an aggravation of the 1979 injury. A determination order issued in February, 1985, awarding TTD and additional PPD. In 1988, claimant was admitted to a hospital for withdrawal **<118 Or App 27/28>** from narcotics. He informed a doctor at a methadone center that he had been using heroin since 1980. The parties do not dispute that the major contributing cause of the drug relapse was claimant's personality disorder. A determination order of September 5, 1989, awarded claimant TTD, but no additional PPD.

Claimant sought a hearing on the September, 1989, determination order, contending that he was permanently and totally disabled as a result of the injuries and his psychiatric condition. The referee held that claimant was not entitled to PTD or to additional PPD. Claimant appealed to the Board, arguing that his claim had been prematurely closed, because his doctors continued to recommend psychiatric and drug dependency treatment and employer had accepted the preexisting personality disorder when it accepted his "psychiatric problems." The Board affirmed, holding that employer had

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[1] The filing of a Form 1502 does not constitute notification to a claimant about the status of the claim. *EBI Ins. Co. v. CNA Insurance*, 95 Or App 448, 450, 769 P2d 789 (1989). Employer's letter referring to the form gave notice to claimant that his aggravation claim had been accepted.

[2] Claimant does not argue that the pre-existing personality disorder was caused or worsened by the compensable injury.

not previously accepted his personality disorder. It concluded that claimant's work injury did not materially contribute[3] to his relapse into drug addiction and that claimant had failed to establish his entitlement to PTD or to additional PPD.

On review, claimant argues that his claim was prematurely closed and that the Board erred in not considering his personality disorder in deciding whether he was medically stationary at the time of claim closure. He contends that employer accepted his personality disorder in 1982 by accepting his "psychiatric problems."

In holding that employer did not accept claimant's personality disorder when it accepted his "psychiatric problems," the Board said:

> "Here, claimant had several diagnosed psychiatric disorders when the employer accepted claimant's psychiatric problems. * * * 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[, 733 P2d 1367] (1987). *See also Kenneth L. Orr*, 43 Van Natta 1432 (1991).
>
> **118 Or App 29>** "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."

*Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), involved a similar issue. In *Piwowar*, the employer accepted the claimant's claim for a "sore back." It then denied the compensability of the disease that had caused the condition. The Supreme Court held that, when the employer accepted the claim for a sore back, its acceptance was broad enough to include any possible cause of that condition. Therefore, it had accepted the compensability of the disease. 305 Or at 501. The court held that an employer cannot escape liability for an accepted condition by merely pointing to a more specific diagnosis for the condition. An employer is held to have accepted the "specific condition in the notice of acceptance regardless of the cause of that condition." 305 Or at 501.

The issue here is what employer accepted. Employer argues that its acceptance of claimant's aggravation claim was not specific enough to encompass the personality disorder. It reasons:

> "[E]mployer in this case did not accept *symptoms*. It accepted a *need* for psychiatric treatment that, according to the medical reports, was needed for depression related to the industrial injury." (Emphasis supplied.)

Although it is true that an employer can accept a "need" for medical treatment, such as surgery for a knee, which will not result in acceptance of the condition, the employer must specify that it is only authorizing medical expenses for that specific treatment. As the Board found, employer here did not so limit its acceptance. The Board found that employer had accepted claimant's "psychiatric problems." That is a finding of fact, *see Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 250, 814 P2d 185 (1991), and employer does not challenge it.

We conclude that, like the "sore back" in *Piwowar*, employer's acceptance of claimant's "psychiatric problems" was not limited to a specific diagnosis, such as dysthymic disorder. By not including an adequate degree of specificity in its acceptance, employer accepted all the possible causes of **<118 Or App 29/30>** claimant's psychiatric problems, including the personality disorder.

Because the Board did not consider the personality disorder in determining when claimant became medically stationary, claim closure was premature. We remand for reconsideration.[4]

Reversed and remanded for reconsideration.

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[3] Because the Board was applying pre-1990 law, the standard for demonstrating compensability was material contributing cause. *See Hicks v. Spectra Physics*, 117 Or App 293, 843 P2d 1009 (1992).

[4] Because of our disposition of this issue, we do not reach claimant's additional arguments.

Cite as 118 Or App 36 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald H. Howard, Claimant.

**LP COMPANY** and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
**DISDERO STRUCTURAL**, FIREMAN'S FUND INSURANCE and RONALD H. HOWARD,
Respondents.
(90-10529, 89-24929, 90-10528, 89-24923; CA A72514)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 26, 1992.

Jenny Ogawa, Salem, argued the cause for petitioners. With her on the brief was Kevin L. Mannix, P.C., Salem.

Jerry K. Brown, McMinnville, argued the cause for respondents Disdero Structural and Fireman's Fund Insurance. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

David C. Force, Salem, argued the cause for respondent Ronald H. Howard. With him on the brief was Vick & Gutzler, Salem.

Before Richardson, Chief Judge, and Deits and Riggs, Judges.

DEITS, J.

Affirmed.

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**118 Or App 38>** Employer, LP Company (LP), seeks review of an order of the Workers' Compensation Board assigning it responsibility for claimant's back injury. We affirm.

Claimant has a history of work injuries. He suffered a compensable injury to his low back in 1984, while working for Disdero Structural (Disdero). Disdero accepted the claim, and a determination order issued in 1985, awarding claimant permanent partial disability (PPD). Claimant continued to experience symptoms. After hanging sheetrock for LP for three days in September, 1989, he sought treatment for low back and neck pain. Claimant's physician diagnosed "thoracolumbar sprain" and authorized his release from work. Claimant filed a claim for a new injury with LP and an aggravation claim with Disdero. Both employers denied responsibility, and an order under ORS 657.307 directed Disdero to pay claimant temporary benefits. Claimant sought review of both denials.

The Board adopted the referee's finding that

> "[c]laimant's work on September 27, preceded by two days of hanging sheetrock resulted in claimant's demonstrating new pathology, being taken off work, and experiencing increased disability. This event occurred over an identifiable, discrete time period and activity so as to qualify it as an injury. *Donald Drake Co. v. Lundmark*, 63 Or App 261, 663 P2d 1303 (1983), *rev den* 296 Or 350 (1984); *Valtinson v. SAIF*, 56 Or App 184, 641 P2d 598 (1982). Thus, there was an identifiable 'incident' with objective signs and symptoms qualifying as an 'injury' under the new law. ORS 656.005(7). This finding is consistent with medical opinions * * *."

Because the Board found that claimant's work at LP "independently contributed to his current low back condition," it set aside LP's denial and remanded the case for acceptance as a new injury. LP seeks review of the Board's order.

Because this case involves a proceeding under ORS 656.307, both the Board's and this court's review is limited to errors of law. ORS 656.307(2); *Liberty Northwest Ins. Corp. v. Oregon Steel Mills*, 105 Or App 547, 550, 805 P2d 741 (1991). LP argues that the Board erred as a matter of law in concluding that claimant suffered a "new injury." It contends that in **<118 Or App 38/39>** 1990, by enacting ORS 656.308(1) and amending ORS 656.005(7), the legislature made a change in what constitutes a "new injury" for purposes of shifting liability in responsibility cases.

ORS 656.308(1), enacted in 1990, provides:

> "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."

ORS 656.005(7)(a), defining a compensable injury, was amended in 1990 to require that proof of a compensable injury be established by objective medical evidence. It now provides:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, 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*[.]" (Emphasis supplied.)[1]

LP argues that these amendments changed the standard for establishing a new injury for purposes of shifting liability in a responsibility case. We have held that an injury can occur "during a discrete period, as compared to the onset of an occupational disease over a long period of time." *Valtinson v. SAIF*, 56 Or App 184, 188, 641 P2d 598 (1982). In *Valtinson*, we held that a claimant with a history of back problems suffered a new compensable injury to his low back when he experienced symptoms after driving on the job for several hours. We said that an injury need not necessarily occur suddenly or instantaneously. 56 Or App at 187. It is **<118 Or App 39/40>** LP's position that, because of the 1990 changes, this case law is no longer viable. It contends that, under the amended statutes, an injury can only be precipitated by a sudden, unexpected, traumatic event.

The new statutory language relied on by LP may make proof of a compensable injury somewhat more difficult. Under ORS 656.005(7)(a), proof of the injury must now be by objective medical findings. However, we do not agree with LP's argument as to the effect of the new language. There is nothing in ORS 656.308(1) or in ORS 656.005(7), as amended, that requires a change in the principle established by case law that an injury need not be instantaneous.

LP argues that its interpretation is correct, because any other reading of the statutes would render meaningless the statutory provisions concerning an occupational disease, specifically, ORS 656.802(1)(c). That provision defines an occupational disease as

> "any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:
>
> "* * * * *
>
> "(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

LP contends that ORS 656.802(1)(c) was intended to include any repetitive trauma as an occupational disease and, accordingly, repetitive trauma can never be an injury. We disagree. The occupational disease statute does not contain a temporal requirement. In contrast, an *injury* based on repetitive trauma must develop within a discrete, identifiable period of time due to specific activity. There is no indication either in the language of the statutes or in the legislative history that the legislature intended to do away with this distinction.

The Board did not err in concluding that claimant suffered a new injury while working for LP. Therefore, it **<118 Or App 40/41>** properly concluded that responsibility for claimant's condition shifted from Disdero to LP.

Affirmed.

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[1] The pre-1990 version of ORS 656.005(7)(a) provided, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, 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."

Cite as 118 Or App 54 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

**LITTLE DONKEY ENTERPRISES, INC.**, Petitioner,

v.

**STATE ACCIDENT INSURANCE FUND**, Respondent.

(88-11-01; CA A72333)

Judicial Review from Department of Insurance and Finance.

Argued and submitted September 18, 1992.

Michael J. Gentry, Portland, argued the cause for petitioner. With him on the briefs were Montgomery W. Cobb, David R. Simon and Tooze Shenker Holloway & Duden, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson,* Chief Judge, and De Muniz and Leeson,** Judges.

DE MUNIZ, J.

Affirmed.

*Richardson, C.J., *vice* Buttler, J., retired.

**Leeson, J., *vice* Joseph, C.J., retired.

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**118 Or App 56>** Petitioner seeks review of an order of the Department of Insurance and Finance (DIF) on remand after our decision in *Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 812 P2d 25 (1991).

We restate the facts for convenience. Petitioner is a transportation management company. It does not own any trucks; it links shippers with truck carriers. Its only facility is an office in a mall complex, where it performs bookkeeping, dispatching and administrative functions. During the audit year 1986-87, it contracted with 29 owner-operators of Class A trucks (18 wheelers) to haul loads for petitioner's shipper customers. Petitioner collected payments from the shippers for loads hauled and paid the owner-operators a percentage of those amounts.

Respondent assessed premiums to petitioner for owner-operators with whom petitioner had contracted. Petitioner requested a hearing. DIF upheld the assessment with respect to owner-operators who operate under petitioner's common carrier license on the theory that, because petitioner retained the right to control the owner-operators' duties and responsibilities, they are petitioner's employees.

In our earlier review, the parties had argued about whether the owner-operators are independent contractors or employees of petitioner. We held that substantial evidence supported DIF's determination that the owner-operators are employees. We also held that, regardless of their status as employees, additional inquiry was necessary to determine whether they might be exempt from compensation coverage under ORS 656.027 as sole proprietors, partners or corporate officers. 107 Or App at 403. We remanded to DIF for it to consider that issue.

On remand, DIF concluded that one owner-operator that had been included in the assessment should have been excluded, because the corporation for whom that trucker worked maintained its own workers' compensation insurance. DIF modified the assessment accordingly. It found no evidence indicating that any other owner-operators should be excluded from coverage.

**118 Or App 57>** On this review, petitioner contends that DIF applied an incorrect legal standard in determining which owner-operators are sole proprietors, partners or corporate officers for the purpose of the exemption under ORS 656.027. We conclude that, in our first opinion, we gave ORS 656.027 a broader reading than the language of the statute justifies and that we should not have remanded the case to DIF for reconsideration.

At the relevant time, ORS 656.027 provided, 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.
>
> "(8) Partners who are not 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.

"(9) A corporate officer who is also a director of the corporation and has a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officer."

In 1989, the legislature amended the statute by adding a condition to subsection (7) that "[w]hen labor or services are performed under contract, the sole proprietor must qualify as an independent contractor." Or Laws 1989, ch 762, 4. The legislature also added language to the exemptions for partners and corporate officers in subsections (8) and (9).

In our first opinion, we inferred that the pre-1989 version of the statute exempted persons who are sole proprietors, partners or corporate officers, "even if they did not qualify as independent contractors." 107 Or App at 403. We were wrong. We now conclude that the 1989 amendments did not substantively change the exemptions. As we read ORS 656.027(7), in both its pre-amendment and amended incarnations, a person who is a sole proprietor of a business is not eligible for workers' compensation coverage for acts performed *in that capacity*, unless that person has elected to be covered under ORS 656.128. The cases cited in our earlier opinion are not to the contrary. *See Bernards v. Wright*, 93 Or **<118 Or App 57/58>** App 192, 760 P2d 1388 (1988); *Lockard v. The Murphy Company*, 49 Or App 101, 109 n 6, 619 P2d 283 (1980), *rev den* 290 Or 519 (1981). A person may simultaneously function as the sole proprietor of a business and as an employee of another business. That person is not barred from coverage while working in the latter capacity. *See Maroon v. Great Western Construction*, 107 Or App 510, 513-514, 811 P2d 1389 (1991). Any suggestion to the contrary in our first opinion in this case is disapproved.

There is no indication that, with respect to their relationships with petitioner, the owner-operators functioned in any of the capacities excluded from coverage under ORS 656.027(7), (8) or (9). In our first opinion, we held that substantial evidence supported DIF's determination that the owner-operators were petitioner's employees, rather than independent contractors. 107 Or App at 402. Now revisiting that holding, we adhere to it.

We reject petitioner's contention that, under ORS 737.505(3),[1] DIF lacked the authority to delete a portion of SAIF's assessment after DIF determined that one owner-operator should have been excluded. Even assuming that that **<118 Or App 58/59>** statute is applicable here,[2] we conclude that DIF had authority to delete a part of the assessment that it determined was incorrect. It was not limited to either affirming or reversing the billing in its entirety.

In the light of our determination that the owner-operators were petitioner's employees and were, therefore, entitled to coverage, we do not reach petitioner's other assignments of error.

Affirmed.

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[1] ORS 737.505 provides, in part:

"(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."

[2] ORS 737.505(3) would appear to apply to appeals of ratings by an insurer or rating organization, not to appeals of final premium audit billings.

Cite as 118 Or App 76 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Vincent L. Kephart, Claimant.

VINCENT L. **KEPHART**, Petitioner,
v.
**GREEN RIVER LUMBER**, LIBERTY NORTHWEST INSURANCE CORPORATION, DILLARD HASS and SAIF CORPORATION, Respondents.
(90-15053 and 90-15054; CA A74706)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 30, 1992.

Edward J. Harri, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll, Eugene.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Dillard Hass. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James D. McVittie, Portland, waived appearance for respondents Liberty Northwest Insurance Corporation and Green River Lumber.

Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.

DE MUNIZ, J.

Affirmed.

*Leeson, J., *vice* Buttler, J., retired.

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**118 Or App 78>** Claimant seeks review of an order of the Workers' Compensation Board holding that his injury is not compensable. We affirm.

Claimant suffered a compensable hand injury in 1982 while working for SAIF's insured, Dillard Hass. From March, 1990, to May 9, 1990, claimant participated in an authorized training program as a long haul truck driver. He injured his shoulder while on a job trial with Green River Lumber as a part of his vocational rehabilitation. SAIF denied the claim. The Board upheld the denial on the ground that, under ORS 656.005(7)(a)(A), the shoulder injury is a consequence of the compensable hand injury and claimant has not established that the hand injury is the major contributing cause of the shoulder injury.

Claimant contends that the shoulder injury is compensable, because it occurred in the course of an authorized training program. Under our decision in *Wood v. SAIF*, 30 Or App 1103, 1106, 569 P2d 648 (1977), he would be correct:

> "The Workers' Compensation Act * * * contemplates [that] the worker is to receive all benefits for an injury including vocational rehabilitation designed to restore the injured worker to full employability. See ORS 656.268(1). The vocational rehabilitation benefits are as much a part of the injured worker's entitlement under the Act as medical treatment for the injury. It follows [that] the vocational retraining in which claimant was involved when he sustained the new injury is a natural and direct consequence of the primary injury."

In 1990, the legislature amended ORS 656.005(7)(a)(A) to provide:

> "A 'compensable injury' is an accidental injury or accidental injury to prosthetic appliances, 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 a compensable injury unless the compensable* **<118 Or App 78/79>** *injury is the major contributing cause of the compensable condition.*" (Emphasis supplied.)

In *Albany General Hospital v. Gasperino*, 113 Or App 411, 414, 833 P2d 1292 (1992), we said:

> "[T]he major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every industrial injury claim. * * * The distinction is between a condition or need for treatment that is caused by the *industrial accident*, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury*. It is the latter that must meet the major contributing cause test." 113 Or App at 414. (Footnote omitted; emphasis in original.)

In *Hicks v. Spectra Physics*, 117 Or App 293, 843 P2d 1009 (1992), we held that an injury that a claimant suffers on the way to the doctor's office for treatment of a compensable injury is not compensable, unless the industrial accident is the major contributing cause of the subsequent injury. We said:

> "Under ORS 656.005(7)(a)(A), *any* injury or condition that is not *directly* related to the industrial accident is compensable *only if* the major contributing cause is the compensable injury." (Emphasis in original.) 117 Or App at 297.

The injury that claimant experienced during vocational rehabilitation is not directly related to the industrial accident. Rather, he experienced it as a consequence of the industrial injury, which had necessitated vocational rehabilitation. Accordingly, under ORS 656.005(7)(a)(A), it is compensable only if the compensable injury is the major contributing cause. The Board, in affirming the referee, held that the compensable injury is not the major contributing cause of the injury that claimant suffered during vocational rehabilitation. Claimant does not dispute that determination.

Claimant would undoubtedly contend that this case is distinguishable from *Hicks*, because he was not injured while *travelling* to vocational rehabilitation, but while *participating* in it. We are not unmindful of that distinction. We conclude, nonetheless, that, as we interpreted ORS 656.005(7)(a)(A) in *Hicks*, its terms are applicable here. **<118 Or App 79/80>** Under the standard established by the statute, the injury is not compensable.

Affirmed.

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Cite as 118 Or App 81 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kenneth V. Hambrick, Claimant.

KENNETH V. **HAMBRICK**, Petitioner,
v.
**WEYERHAEUSER CO.**, Respondent.
(89-10273; CA A70739)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 15, 1992.
Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.
Brian Pocock, Eugene, argued the cause and filed the brief for respondent.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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**118 Or App 83>** Claimant seeks review of a Worker's Compensation Board order that awarded him 17 percent permanent partial disability (PPD) for the loss of use or function of his left forearm. He contends that the award should have been based on an injury to his arm, not his forearm. We affirm.

Claimant sustained a work-related tear of the left biceps muscle, which required a surgical reattachment of the tendon to the radius below the elbow. The Board awarded him 17 percent PPD for his forearm.

Claimant argues that the Board misconstrued ORS 656.214(2), because it restricted its disability rating to the site of the injury and should have rated the permanent loss of use or function to his injured member, which he contends is his arm. He also argues that the Board misapplied its definitions of forearm and arm, because he has lost the use or function of his arm, not his forearm, because of disabling pain in his elbow.

ORS 656.214 provides, in part:

"(1) As used in this section:

"(a) 'Loss' includes permanent and complete or partial loss of use.

"(b) 'Permanent partial disability' means the loss of either one arm, one hand, one leg, one foot, loss of hearing in one or both ears, loss of one eye, one or more fingers, or any other injury known in surgery to be permanent partial disability.

"(2) 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.* The worker shall receive $305 for each degree stated against such disability in subsections (2) to (4) of this section as follows:

"(a) For the loss of one *arm at or above the elbow joint*, 192 degrees, or a proportion thereof for losses less than a complete loss.

"(b) For the loss of one *forearm at or above the wrist joint*, or the loss of one hand, 150 degrees, or a proportion thereof for losses less than a complete loss." (Emphasis supplied.)

**118 Or App 84>** The forearm is defined as the area from or above the wrist joint to the elbow joint, and the arm is the area from or above the elbow joint. OAR 436-35-020(1), (2).[1]

The Board did not misconstrue ORS 656.214(2) or misapply the definitions. The statute requires the Board to determine the "member," *i.e.*, the body part or organ, that has been disabled by the injury. Relying on the testimony of the treating physician, it found that the disability originated at the point of the surgical repair below the elbow. The reattachment resulted in pain around the repair, scar tissue and weakness. He has suffered atrophy to the forearm. The surgery did not restrict claimant's ability to flex and supinate his elbow, and he lost no range of motion.

Substantial evidence supports the Board finding that the disabled body part is the forearm. The Board correctly applied the rule to determine that that was the "injured member," ORS 656.214(2), and assessed the loss of use or function to that member. The disability rating was based on correct criteria.

Affirmed.

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[1] OAR 436-35-020(1), (2) has since been amended in a way that does not affect this case.

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Cite as 118 Or App 85 (1993) February 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Carole J. Damm, Claimant.

CAROLE J. **DAMM**, Petitioner,
v.
**WASHINGTON COUNTY SCHOOL DISTRICT** #7 and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(88-05479, 90-13344; CA A71603 (Control) CA A71916)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 15, 1992.
Darrell E. Bewley, Salem, argued the cause for petitioner. With him on the brief was Richard F. McGinty, Salem.

Alexander D. Libmann, Trial Counsel, Liberty Northwest Insurance Corporation, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

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**118 Or App 87>** Claimant seeks review of two Worker's Compensation Board orders determining that neither her back condition nor mental depression is compensable. The two orders are consolidated for review. Initially, the Board found that claimant's work was a material contributing cause of her back condition. We remanded for reconsideration in light of our decision in *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844, *rev den* 312 Or 150 (1991). *Liberty Northwest Ins. Corp. v. Damm*, 107 Or App 764, 812 P2d 854 (1991). On remand, the Board found that claimant's work was not the major contributing cause of her back condition. Claimant subsequently brought a claim for depression that she claimed resulted from her back problems. The Board concluded that the depression was not compensable, because the back condition was not compensable. We affirm the orders.

Claimant has been a school bus driver for 21 years. In February, 1988, she experienced numbness in her left leg while driving a bus. Forty-five minutes later, she stopped the bus and got up to move around. Her left foot remained numb and she noticed lower-back pain. She had experienced similar symptoms in the past but never of such duration or intensity.

On her way home from work, she visited Dr. Kim, an internist, who referred her to Dr. Peterson. Peterson advised employer's insurer:

> "I feel the patient's leg complaints are sciatica, that is mild nerve root compression starting in the back, caused by her degenerative changes.
>
> "I do not think that the patient's osteoporosis is contributing to her back problem. I think the major contributing cause of the development of her degenerative disk disease is a combination of her industrial exposure and predisposition to degenerative changes. The percentage of contribution of each cannot be determined. I do not think osteoporosis has anything to do with her current pain complaints. I do think [claimant's] driving did cause material worsening of the underlying condition."

Independent medical examiners found that claimant's lower back problems arose primarily from natural processes but could not state that work had not contributed to **<118 Or App 87/88>** her degenerative condition. They found that claimant's age and obesity were also factors and that driving the school bus had aggravated the condition, but they could not specify the extent of that contribution.

The Board found that claimant's work exposure was not the major contributing cause of her back condition. Claimant contends that the Board misinterpreted Peterson's report. Although Peterson initially opined that the disc disease was caused in major part by a *combination* of work exposure and her predisposition to degenerative changes, he said that he could not determine the percentage of contribution of each source to the disc disease. He also stated that her driving caused a "material worsening of her underlying condition." Even if the latter statement is construed as a comment on the extent of the worsening and not its cause, Peterson's inability to determine the extent to which work exposure contributed to the condition justifies the conclusion that the report did not establish the major contributing cause of her back problems. The Board found that neither of the two medical opinions on the issue of causation established that work activities were the major contributing cause of her back condition. Substantial evidence supports the Board's finding. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). Because claimant's back injury is not compensable, neither is her depression.

Affirmed.

Cite as 118 Or App 183 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Harlie B. Gilliam, Claimant.

**VIKING INDUSTRIES** and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
HARLIE B. **GILLIAM**, Respondent.
(90-11937; CA A73511)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1992.
Joanne Williams Mills, Portland, argued the cause for petitioners. With her on the brief were David Jay Lefkowitz and Schwabe, Williamson & Wyatt, Portland.
Merrill Schneider, Portland, argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Reversed.
*Leeson, J., *vice* Buttler, J., retired.

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**118 Or App 185>** Employer seeks review of an order of the Workers' Compensation Board holding that it wrongfully refused to pay claimant benefits for temporary total disability.

Claimant had a compensable left wrist injury. He lost no time from work until he sought medical treatment from Dr. McCaffey on August 14, 1989. McCaffey released claimant to modified work that same day, and claimant returned to modified work for employer on August 15. Claimant had been at work for a short time when he was asked by employer to submit to a drug test. Employer informed claimant that his failure to take the test would be treated as a "voluntary quit." Claimant did not take the test.

The Board found that claimant had returned to modified work and that he quit by refusing to take the drug test.[1] Those findings are supported by substantial evidence. The Board held that employer wrongfully failed to begin payment of benefits for temporary total disability, because it had not given him a written offer of employment, as required by ORS 656.268(3)(c). The parties agree that subsection (3) is applicable. That subsection provides:

> "Temporary total disability benefits shall continue until whichever of the following events occurs first:
>
> "(a) The worker returns to regular or modified employment;
>
> "(b) The attending physician gives the 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."

The three paragraphs are stated in the disjunctive. Any one of them provides an adequate basis for terminating benefits. Claimant returned to modified work; accordingly, employer was entitled to terminate benefits for temporary disability under ORS 656.268(3)(a), and was not required to make a written offer of employment.

Reversed.

---

[1] We are not called upon to review the Board's legal determination that, by refusing to take the drug test, claimant voluntarily quit.

Cite as 118 Or App 186 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Esther C. Albertson, Claimant.

ESTHER C. **ALBERTSON**, Petitioner,
v.
**ASTORIA SEAFOOD CORPORATION** and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(91-04143; CA A74705)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1992.
Jan H. Faber, Astoria, argued the cause for petitioner. With him on the brief was Patrick Lavis, P.C., Astoria.
Alexander D. Libmann, Portland, argued the cause for respondents. With him on the brief was James D. McVittie, Portland.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Affirmed.
*Leeson, J., vice Buttler, J., retired.

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**118 Or App 188>** Claimant seeks review of an order of the Workers' Compensation Board holding that it does not have jurisdiction to consider claimant's request for the assessment of a penalty for employer's unreasonable request for a suspension of benefits for temporary total disability.

On February 12, 1991, employer applied to the Director of the Department of Insurance and Finance, through the Compliance Division, for a suspension of claimant's benefits for temporary total disability, on the ground that claimant had failed to attend a scheduled independent medical examination. ORS 656.325(1); OAR 436-60-095. Claimant, in turn, requested that the Director impose sanctions and assess attorney fees against employer for acting in bad faith in requesting the suspension. On February 25, 1991, the Director denied the suspension of benefits. As to claimant's request for sanctions, the Director said that he had "no statutory authority for imposing such sanctions."

Claimant could have requested review of the Director's decision under ORS chapter 183. ORS 656.262(10)(a). Instead, she requested a hearing, seeking a penalty and attorney fees under ORS 656.262(10)(a), which provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. 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. The director's action and review thereof shall be subject to ORS 183.310 to 183.550 and such other procedural rules as the director may prescribe."

We agree with the Board that the only matter involved in this dispute is the assessment of a penalty under ORS 656.262(10) **<118 Or App 188/189>** and the related attorney fee. *See Oliver v. Norstar*, 116 Or App 333, 840 P2d 1382 (1992). The Board had no jurisdiction to consider the matter.

Affirmed.

Cite as 118 Or App 201 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of the Beneficiaries of Harold T. Bird, Deceased, Claimant.

ROSEMARY **BIRD**, Beneficiary of Harold T. Bird, Deceased, Petitioner,
v.
**BOHEMIA, INC.** and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 90-18895; CA A73448)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 30, 1992.
Edward J. Harri, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll, Eugene.
David O. Wilson, Eugene, argued the cause for respondents. With him on the brief was Employer's Defense Counsel, Eugene.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.

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**118 Or App 203>** Claimant seeks review of an order of the Worker's Compensation Board upholding employer's refusal to pay widow's benefits pending appeal of the referee's order holding that she is entitled to the benefits. We affirm.

Claimant is the widow of Bird, who worked for employer. In 1989, she filed a claim seeking widow's benefits, alleging that Bird's death resulted from a compensable injury or disease that was caused by his work with employer. Employer denied the claims, and a hearing on compensability was held in December, 1989. In August, 1990, the referee issued an order setting aside the denials and ordering employer to "accept the claim for processing and payment of benefits according to law." Employer appealed the referee's order to the Board, but refused to pay benefits pending appeal. On October 3, 1990, claimant requested a hearing on employer's refusal.[1] The referee held that employer's refusal to pay benefits pending appeal was proper, and the Board affirmed the referee's order. Claimant seeks review of the Board's order.

This case arises because of the 1990 amendments to ORS 656.313. Before amendment, the statute required an insurer to pay all compensation pending appeal except medical expenses.[2] Under

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[1] In the compensability case, the Board reversed the referee and upheld the denial. We affirmed the Board. *Bird v. Bohemia, Inc.*, 113 Or App 233, 832 P2d 1276 (1992).

[2] ORS 656.313(1) and (4) provided:

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

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

that version of ORS 656.313, claimant would have received benefits pending appeal. Under the amended statute, with certain exceptions, benefits are *not* paid pending appeal.[3] The benefits at issue here do not come **<118 Or App 203/204>** within any of the exceptions and, thus, would not be payable pending appeal. The question presented here is which version of ORS 656.313 applies here.

Section 54 of Senate Bill 1197 delineates the effective date of the 1990 amendments to the Workers' Compensation Act:

> "(1) 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, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section.
>
> "(2) *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." Or Laws 1990, ch 2, 54(1) and (2). (Emphasis supplied.)

The parties read the language of section 54 quite differently. Employer argues that claimant's October, 1990, request for a hearing on its refusal to pay benefits pending appeal is a separate case from the one in which the compensability of the underlying claim was litigated. Employer points out that a separate request for hearing initiated this case and that it was litigated under a different Worker's Compensation Board case number. Employer contends that, because the request for hearing was made after May 1, 1990, the amended version of ORS 656.313 applies.

Claimant argues that the payment of benefits pending appeal does not involve a separate claim from the underlying compensability claim. She asserts that, because the **<118 Or App 204/205>** request for hearing in the underlying claim was filed before May 1, 1990, and a hearing on that matter was commenced before July 1, 1990, this case involves a matter regarding a claim that was in litigation before the relevant dates in section 54 and that the pre-amendment version of ORS 656.313 is applicable. *See Carlson v. Valley Mechanical*, 115 Or App 371, 838 P2d 637 (1992).

In interpreting a statute, our task is to give effect to the intention of the legislature. To that end, we look first to the language of the statute. ORS 174.010; ORS 174.020, *State v. Tyler*, 108 Or App 378, 815 P2d 1289 (1991). Section 54 provides that a matter will be resolved under the law applicable before the 1990 amendments, if it is a "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." (Emphasis supplied.) The term "matter" is not defined in the statutes. However, it is apparent from its use that it has a meaning, different from the term "claim" and that it was intended to have a more narrow meaning than "claim." We agree with the Board's explanation:

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[3] ORS 656.313 now provides, in part:

"(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; and

"(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed.

"(b) If ultimately found payable under a final order, benefits withheld under this subsection shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment. The board shall expedite review of appeals in which payment of compensation has been stayed under this section."

> "[I]n the present case, the question of whether payment of death benefits is stayed pending the appeal is a separate 'matter' which arose (i.e., became at issue) after the earlier compensability determination. Inasmuch as claimant's hearing request regarding this 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). See Raymond J. Seebach, supra.* Therefore, this case was properly analyzed by the Referee under *amended* ORS 656.313." (Emphasis supplied.)

The Board did not err in upholding employer's refusal to pay benefits pending appeal of the referee's order.

Affirmed.

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Cite as 118 Or App 241 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jeffrey D. Skochenko, Claimant.

JEFFREY D. **SKOCHENKO**, Petitioner,
v.
**WEYERHAEUSER COMPANY**, Respondent.
(90-13603; CA A71813)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 18, 1992.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Hugh K. Cole and Coons, Cole & Carey, P.C., Eugene.

John M. Pitcher, Springfield, argued the cause for respondent. Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, J.

Reversed and remanded for reconsideration of compensability of herniated disc.

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**118 Or App 243>** Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of his occupational disease claim. Reviewing for substantial evidence, we reverse and remand.

Claimant, who was 31 years old at the time of the hearing, has congenital bilateral spondylolesis and spondylolythesis at L5-S1 that results in instability in the low back, and a herniated disc at L5-S1. He first had low back problems at the age of 12, after a fall. He has worked for employer for 12 years. He spends 40 percent of his time as a "fourth hand" and 60 percent of his time as a "fifth hand." As a "fourth" hand, claimant is required to do repetitive bending and twisting to stencil rolls of paper. As a "fifth hand," he is responsible for 'winding' and 'tapping down' rolls of paper, which requires him to jump down from a waist-high winder table to a cement floor 16 to 60 times per shift and also involves repetitive bending.

In 1985, claimant began to have pain in his low back and left buttocks. He consulted with a chiropractor, more than 50 times during the next four years. In 1989, he consulted with Dr. Parsons, a neurosurgeon, who diagnosed a preexisting congenital spondylolythesis and a preexisting spondylolesis at L5-S1. In early 1990, Parsons referred claimant to Dr. Gripekoven, an orthopedic surgeon, for consultation. An MRI scan showed the disc herniation at L5-S1. In May of 1990, claimant had surgery. Claimant is now virtually symptom free.

In June, 1990, employer denied the compensability of claimant's lumbar spondylolythesis, bilateral spondylolesis and protruded disc. Claimant sought review of those denials. The referee upheld the denials, concluding that the spondylolesis and the spondylolythesis were congenital conditions unrelated to claimant's work activities, and that "[c]laimant's work activities as a 'fourth and fifth man' made some contribution to the L5-S1 disc herniation, but were not the major cause of that herniation." The Board affirmed.

At issue is whether claimant's work activity was the *major contributing cause* of any of his low back problems. *See* ORS 656.802(2). The Board relied primarily on the opinions **<118 Or App 243/244>** of Gripekoven and Parsons in concluding that they were not. It stated that Gripekoven and Parsons "basically agree that claimant's low back problems were not caused in major part by his work activities." Claimant argues that the Board misread their medical opinions. He contends, relying on *Asten-Hill Co. v. Armstrong*, 100 Or App 559, 787 P2d 890 (1990), that, because the Board misinterpreted the reports, its decision is not supported by substantial evidence.

Gripekoven and Parsons concluded that claimant's spondylolesis and spondylolythesis were congenital conditions unrelated to his work activities. Both doctors agreed that the herniated disc was caused by physical stress, but could not state whether claimant's work activities were the major contributing cause. Gripekoven said:

> "*I can not state with certainty that [claimant's] work activities were the underlying major contributing factor in the development of the disc herniation.* His work activities would be combined with all other physical activities to have contributed to the herniation. *Obviously his work activity presented a major challenge to his back but I really could not state with certainty whether this was the cause of the preponderance of stress in this area.*" (Emphasis supplied.)

Parsons stated:

> "[Claimant] was found to also have a protrusion of the lumbosacral disk, the same level as his congenital instability. The disk protrusion is felt to be the result of physical stress on the disk. The congenital instability increases the risks that physical forces may cause protrusion of the disk. * * * [T]here is no history of a single event or injury that caused the disk protrusion. It is therefore probably a culmination of physical stresses, both at work and otherwise, over a period of years that resulted in his disk protrusion. *In this circumstance there is no method to medically determine the "major contributing factor".* It is certainly possible that his work activities may have contributed to his disk protrusion which ultimately required surgery. *I can not state that his work activities based upon medical probability was [sic] the major contributing factor in his condition.*" (Emphasis supplied.)

The Board's statement that Gripekoven and Parsons agree that claimant's work activities were not the major cause of his herniated disc is not correct. The doctors said that they **<118 Or App 244/245>** could not determine to a reasonable degree of medical certainty that work activities were the major contributing cause of his condition. They did not say that the work activities were not the major cause. Particularly in view of the other medical evidence that claimant's work activity was the major contributing cause of his condition, we cannot say that the Board's misinterpretation of some of the medical evidence did not influence its ultimate conclusion about the herniated disc. Accordingly, we must reverse and remand for reconsideration. *See Asten-Hill Co. v. Armstrong, supra.*

Reversed and remanded for reconsideration of compensability of herniated disc.

Cite as 118 Or App 261 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Betty J. Smith-Sanders, Claimant.

**MEIER & FRANK CO.** and MAY DEPARTMENT STORES COMPANY, Petitioners,
v.
BETTY J. **SMITH-SANDERS**, Respondent.
(89-18180; CA A69500)

Judicial Review from Workers' Compensation Board.

On respondent's motion for reconsideration. Opinion filed September 9, 1992. 115 Or App 159, 836 P2d 1359.

Glen H. Downs, Portland, for motion.

Jerald P. Keene, Portland, contra.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, P.J.

Motion for reconsideration allowed; opinion adhered to as modified; award of attorney fees related to medical services reversed; otherwise affirmed.

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**118 Or App 263>** Claimant moves for reconsideration of our opinion. 115 Or App 159, 836 P2d 1359 (1992). We allow reconsideration on the issue of attorney fees. We reversed the Board's award of attorney fees for services related to medical services and for services related to claimant's entitlement to temporary total disability. However, as employer agrees, that part of the award of fees based on the temporary total disability dispute was not challenged on review. Accordingly, we modify the disposition to reverse only that portion of the award of attorney fees related to the medical services dispute.

We also note that the designation of employer as the prevailing party does not preclude claimant from seeking attorney fees under ORS 656.382(2).

Motion for reconsideration allowed; opinion adhered to as modified; award of attorney fees related to medical services reversed; otherwise affirmed.

Cite as 118 Or App 277 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Christine DeGrauw, Claimant.

CHRISTINE **DEGRAUW**, Petitioner,
v.
**COLUMBIA KNIT, INC.**, and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
(91-11604; CA A74033)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1992.
Merrill Schneider, Portland, argued the cause and filed the brief for petitioner.
Alexander D. Libmann, Trial Counsel, Liberty Northwest Insurance Corporation, Portland, argued the cause for respondents.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
DE MUNIZ, J.
Reversed and remanded with instructions to order employer to process the claim as disabling.
*Leeson, J., *vice* Buttler, J., retired.

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**118 Or App 279>** Claimant seeks review of an order of the Workers' Compensation Board holding that the insurer was permitted to reclassify her claim from disabling to nondisabling, but that the Board did not have jurisdiction to consider the merits of the resulting classification.

Claimant developed back problems in 1988, while working for employer. She first sought treatment in August, 1989, and on September 29, 1989, filed a claim for a back injury. In February, 1990, Liberty Northwest Insurance Corp. (Liberty) accepted a claim for a disabling lumbosacral strain. In September, 1990, it issued a second notice of acceptance, in which it described the claim as nondisabling.

Claimant did not seek review of that determination by the Department of Insurance and Finance (DIF), as provided by ORS 656.262(6)(c), believing that, because the reclassification had not occurred until more than one year after the date of the injury, a request would have been untimely. Instead, she requested a hearing, protesting the reclassification of the claim.

In affirming the referee, the Board held that there was no statutory bar to reclassifying a claim from disabling to nondisabling. It concluded, however, that the time limitation was inapplicable, because the claim had been reclassified more than one year from the date of the injury and it would be impossible for claimant to comply with the requirement of ORS 656.262(6)(c) that the request to DIF be made within one year of the date of the injury. It held that claimant had no deadline for challenging the reclassification with DIF, but that she must do that before seeking a hearing. Accordingly, the Board ruled that it could not decide the merits of the appeal.

The pertinent statutes do not expressly permit or prohibit reclassification of a claim. ORS 656.268(4)(e) and (5) provide:

> "(e) If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section.
>
> "* * * * *
>
> **118 Or App 280>** "(5) Within 10 working days after the department receives the medical and vocational reports relating to an accepted disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the department may require additional medical or other information with respect to the claim, and may postpone the determination or reconsideration for not more than 60 additional days. 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. At the reconsideration proceeding, the worker or the insurer or self-insured employer may

correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

ORS 656.277 provides:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation.

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

"(a) When a notice of claim denial is filed;

"(b) When the status of the claim is as described in subsection (1) or (2) of this section;

"(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon; or

"(d) When otherwise required by the director."

ORS 656.262(6) provides, in part:

"The notice of acceptance shall:

**118 Or App 281>** "(a) Specify what conditions are compensable.

"(b) Advise the claimant whether the claim is considered disabling or nondisabling.

"(c) Inform the claimant of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries, *including the right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon pursuant to ORS 656.268 within one year of the date of injury.*" (Emphasis supplied.)

The substantive advantage to the employer of classifying a claim as nondisabling is that the aggravation rights run from the date of the injury rather than from the date of the first determination order or notice of closure. ORS 656.273(4).

Claimant contends that, although there is no statute specifically prohibiting an insurer from reclassifying a claim from disabling to nondisabling more than one year from the date of the injury, that procedure is contrary to the statutory scheme. We agree. As contemplated by ORS 656.262(6)and ORS 656.268, a claimant is entitled to reconsideration by DIF of the employer's decision to reclassify the claim as nondisabling. If the claim is reclassified more than one year from the date of the injury, the claimant is precluded, through no fault of her own, from seeking reconsideration by DIF. We conclude that, if an employer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of the injury. If, as here, it does not act within one year, then it must process the claim to closure. The notice of closure or determination order can then be reconsidered by DIF pursuant to ORS 656.268(4)(e) or (5).

Reversed and remanded with instructions to order employer to process the claim as disabling.

Cite as 118 Or App 282 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Edwin E. Hegerberg, Claimant.

**LIBERTY NORTHWEST INSURANCE CORPORATION** and COLAMETTE CONSTRUCTION COMPANY, Petitioners,
v.
EDWIN E. **HEGERBERG**, NORTH PACIFIC ELECTRIC and SAIF CORPORATION, Respondents.
(90-18103, 90-12443, 90-18104, 90-12444; CA A71448)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 18, 1992.

Kathryn Olney, Portland, argued the cause for petitioners. On the brief was Stafford J. Hazelett, Portland.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents North Pacific Electric and SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondent Edwin E. Hegerberg.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

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**118 Or App 284>** Petitioners Liberty Northwest Insurance Company (Liberty) and its insured, Colamette Construction Company (Colamette), seek judicial review of a Worker's Compensation Board order holding that Liberty is responsible for claimant's compensation. We affirm.

Colamette was the general contractor on a construction project at Portland Adventist Hospital. On June 23, 1989, Colamette subcontracted with North Pacific Electric (NPE), a three-person partnership, to perform certain electrical work. NPE began work shortly thereafter. Although the contract provided that NPE was responsible for its own workers' compensation insurance, NPE did not obtain insurance due to the partners' belief that it was exempt under ORS 656.027(8).[1] By mid-August, 1989, two partners became disenchanted and quit working, although the partnership was not dissolved. One partner, Schwarz, continued the work. On November 17, 1989, Schwarz' ex-wife incorporated NPE, and the corporation, North Pacific Electric, Inc. (NPE, Inc.), assumed NPE's contract with Colamette. NPE, Inc., hired claimant in December, 1989. NPE, Inc., did not obtain workers' compensation coverage.

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[1] ORS 656.027(8) provided:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(8) Partners who are not 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."

In this opinion, we refer to the versions of ORS 656.027 and ORS 656.029 in effect when work commenced under the contract. Those statutes were later amended. Or Laws 1989, ch 762, 4, 5. The amendments have no effect on the result in this case.

Claimant was compensably injured on February 13, 1990. NPE, Inc., assured him that its workers' compensation carrier would cover his surgery and time loss, but later admitted that it did not have coverage. Claimant filed a claim. On April 25, 1990, the Director of the Department of Insurance and Finance concluded that Liberty was responsible for coverage under ORS 656.029(1) and that NPE, Inc., was not responsible. The Director sent the claim to Liberty for processing and also sent it to SAIF for denial on behalf of the **<118 Or App 284/285>** fund for noncomplying employers. ORS 656.054. SAIF denied the claim on May 3, 1990. Liberty initially accepted the claim and began paying benefits, but on June 8, 1990, it denied responsibility and denied the claim. Claimant requested a hearing on the denials. The Board held that Liberty was responsible for claimant's compensation.

ORS 656.029 provided:

> "(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.
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> "* * * * *
>
> "(4) As used in this section:
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> "(a) 'Person' includes partnerships, joint ventures, associations, corporations and sole proprietorships.
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> **118 Or App 286>** "(b) 'Sole proprietorship' means a business entity or individual who performs labor without the assistance of others."

The Board referred to "the person awarding the contract" as the prime contractor and "the person to whom the contract is awarded" as the subcontractor. We will follow the Board's nomenclature. Subsection (1) assigns responsibility for coverage for a subcontractor's nonexempt worker to the prime contractor unless the subcontractor "provides such coverage for those individuals before labor under the contract commences." However, if the subcontractor is exempt from coverage under ORS 656.027 and employs a nonexempt worker without obtaining coverage, subsection (2) treats the subcontractor as a noncomplying employer. ORS 656.054 makes SAIF responsible for benefits payable by a noncomplying employer.

Liberty contends that subsection (2) controls this case because NPE, Inc., was a noncomplying employer. Liberty makes several arguments to support its position. First, it contends that, when labor commenced under the contract in June, 1989, NPE was exempt as a sole proprietorship under ORS

656.027(7),[2] and NPE, Inc., assumed that exemption when it incorporated and assumed the contract. Second, it contends that NPE, Inc., was exempt because, when it commenced labor under the contract upon its incorporation in November, 1989, Schwarz, the sole shareholder, was exempt as a corporate officer under ORS 656.027(9).[3] Third, it contends that Colamette gave several change orders regarding **<118 Or App 286/287>** the work to NPE, Inc., after it incorporated, that the change orders were new contracts and that the corporate officer exemption applied when those new contracts were awarded.

The Board correctly rejected those arguments. Colamette awarded the contract to NPE, not to NPE, Inc., and, at that time, NPE was a three-person partnership, not a sole proprietorship or a single shareholder corporation. NPE was not exempt from coverage under ORS 656.027(7) or (9) when the contract was awarded. Colamette's responsibility for coverage under ORS 656.029(1) is not affected by the incorporation of NPE, Inc., because the contract had been awarded to a nonexempt subcontractor, NPE, and labor had commenced. We reject Liberty's argument that we should determine NPE, Inc.'s, right to an exemption on the date that it incorporated. That would defeat the legislature's intention in ORS 656.029(1) to fix responsibility for obtaining coverage on "the person to whom the contract is awarded," to require that person to fulfill the duty "before labor under the contract commences" and, if the subcontractor violates its obligation, to hold the prime contractor responsible for coverage.

Colamette's issuance of change orders to the contract does not alter our conclusion. Under the contract, change orders do not nullify the contract but become a part of it. Issuing a change order to an existing subcontract is not the equivalent of awarding a separate contract under ORS 656.029.

Colamette awarded one contract, and the entity to whom it was awarded, NPE, was not exempt from coverage under ORS 656.027(7) or (9). NPE failed to provide coverage before labor commenced under the contract. In that circumstance, ORS 656.029(1) required Colamette to provide coverage. The Board correctly held that Liberty was responsible for claimant's compensation.

Affirmed.

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[2] ORS 656.027(7) provided:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors."

In *Little Donkey Enterprises, Inc. v. SAIF*, 118 Or App 54, ___ P2d ___ (1993), we held that the sole proprietor exemption required proof that the person qualified as an independent contractor. The statute was amended in 1989 to include that requirement. Or Laws 1989, ch 762, 4.

[3] ORS 656.027(9) made an exemption for:

"A corporate officer who is also a director of the corporation and has a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officer. However, if the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS 215.203 and ORS chapter 308, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption."

Cite as 118 Or App 288 (1993) February 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald A. Hutchison, Claimant.

DONALD A. **HUTCHISON**, Petitioner,
v.
**FRED MEYER, INC.**, Respondent.
(90-13199; CA A71931)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 18, 1992.
Karen Stolzberg, Portland, argued the cause for petitioner. With her on the brief was Goldberg & Mechanic, Portland.
Brad G. Garber, Portland, argued the cause for respondent. On the brief were Deborah Sather and Cooney, Moscato & Crew, P.C., Portland.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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**118 Or App 290>** Claimant seeks review of a Worker's Compensation Board order that held that employer's denial of his claim was not unreasonable and declined to award him a penalty. The issues are whether employer unreasonably denied the claim or unreasonably refused to rescind the denial. ORS 656.262(10).[1] We affirm.

Employer accepted a claim for bilateral carpal tunnel syndrome (CTS), and the claim was closed by a determination order on April 24, 1990. Claimant had surgery. After returning to work, he still experienced pain. On May 8, 1990, Dr. Ebert stated that claimant's new symptoms were consistent with CTS and noted that claimant had mild underlying sensory peripheral neuropathy, caused by his past alcohol abuse. He recommended surgery for recurrence of CTS. Claimant filed a new claim, and employer denied it on June 6, 1990.

Claimant told Ebert about the denial. On June 7, 1990, Ebert wrote that the CTS was compensable and that the neuropathy was only a minor factor in claimant's condition. The record also contains reports from Dr. Long on June 20, 1990; Dr. Nathan on August 1, 1990, and Dr. Ochoa on September 26, 1990, regarding the condition.

Claimant underwent surgeries on June 21 and July 5, 1990. On November 7, 1990, two days before the scheduled hearing, employer rescinded its denial and reopened claimant's claim. The Board found that claimant's attorney was instrumental in effecting employer's rescission of the denial and awarded attorney fees. ORS 656.386(1). It denied claimant's request for a penalty for an unreasonable denial, ORS 656.262(10), because it found that the denial was not unreasonable.

In *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591, 763 P2d 408 (1988), we said:

> **118 Or App 291>** "Whether a denial is reasonable or unreasonable involves both legal and factual questions. We review for errors of law in examining whether the Board applied the correct legal standard. ORS 183.482(8)(a). That standard is whether, from a legal standpoint, [the insurer] had a legitimate doubt as to its liability. If so, the denial was not unreasonable. *Norgard v. Rawlinsons*, 30 Or App 999, 1003, 569 P2d 49 (1977). 'Unreasonableness' and 'legitimate doubt' are to be considered in the light of all the evidence available to the insurer. *See Ginter v. Woodburn United Methodist Church*, 62 Or App 118, 122, 659 P2d 434 (1983)."

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[1] ORS 656.262(10) provides, in part:

> "(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

Whether the denial was unreasonable is determined in the first instance by examining the facts and circumstances as they existed when employer denied the claim. *Ginter v. Woodburn United Methodist Church, supra.* When employer issued its denial, the only medical evidence before it was Ebert's May 8 letter:

> "In all probability, [claimant's] recurring symptomatology is due to an underlying, very mild sensory peripheral neuropathy. The sensory peripheral neuropathy, presumably, is related to his history of alcohol consumption in years past, which is not a current problem, incidentally. But, the patient does have a mild sensory peripheral neuropathy, which in all probability makes the nerves more susceptible to mechanical compression, as is typical of carpal tunnel syndrome."

From that, employer could have reasonably concluded that claimant's condition was caused by sensory peripheral neuropathy, which in turn stemmed from his alcoholism, and was not work-related.

A reasonable denial can become unreasonable if new medical evidence removes the employer's legitimate doubt about its liability. *See Georgia-Pacific Corp. v. Arms*, 106 Or App 343, 347, 807 P2d 331 (1991); *Brown v. Argonaut Insurance Company, supra,* 93 Or App at 592. Claimant argues that employer received information after its denial that rendered continuation of the denial unreasonable. Ebert's second letter, written June 7, 1990, after claimant had informed him of the denial, said:

> "It is my understanding that Alexis Risk Management accepted [claimant's] claim initially and authorized and paid for the initial operation on each hand. The accepted condition was bilateral carpal tunnel syndrome.
>
> **118 Or App 292>** "In my May 8, 1990 dictation I noted his initial response to the surgery was very good but subsequently his symptomatology has returned. There is no question that his employment as a meat cutter for Fred Meyer, Inc., materially aggravates his symptomatology and is a contributing cause.
>
> "I have recently been informed that his current claim was disallowed on the basis that his current condition is due to alcohol. Please allow me to clear up the confusion. [Claimant's] peripheral neuropathy makes him more susceptible to mechanical compression than if he did not have the peripheral neuropathy. However, this is not the only causal factor to be considered in [his] recurrent bilateral carpal tunnel syndrome. Bilateral carpal tunnel syndrome is due to mechanical compression. The nerves may be more susceptible to mechanical compression as a result of sensory peripheral neuropathy. But that is certainly not the only causal factor. Thus, the causal factor which (within reasonable medical probability) made [claimant] more susceptible to the mechanical compression which he has is P[eripheral] N[europathy]. There simply is no intelligent rationale for allowing the claim initially and then subsequently deciding not to allow it now. [Claimant's] initial diagnosis * * * was bilateral carpal tunnel syndrome and [he] had a minor peripheral neuropathy at that time. If [his] only diagnosis was sensory peripheral neuropathy then I would agree with you that this is not a compensable work related disorder. But that is not the only diagnosis. [Claimant] has a moderate to marked right carpal tunnel syndrome and a mild to moderate left carpal tunnel syndrome.
>
> "Thus, to clarify the first sentence on page 3 of my May 8, 1990, dictation, in all probability [claimant's] recurrent symptomatology is partially due to an underlying very mild sensory peripheral neuropathy. In addition, of course, the carpal tunnel syndrome is due to mechanical compression. Thus I recommend that you authorize the current recommended surgery under his workers' compensation claim."

Long wrote on June 20, 1990, that he did not see any evidence of diffuse polyneuropathy and that claimant's alcoholism could not be "considered a significant contributor to any of [claimant's] current symptoms or to the need for any additional treatment." He did not say that claimant's CTS was work-related. On August 1, 1990, Nathan wrote that he found no evidence of polyneuropathy but found that claimant had entrapment neuropathies that were not caused by his **<118 Or App 292/293>** work activities. On September 26, 1990, Ochoa found "clear signs of a predominantly sensory polyneuropathy," but said that "at this stage * * * it is not the direct cause of the symptoms."

The Board found that employer was not notified that claimant's polyneuropathy was not the cause of his CTS until it received Ochoa's letter. In his June 7, 1990, letter, Ebert attempted to clarify that claimant's condition was compensable but failed to do so. He said that claimant's symptoms were partially due to peripheral neuropathy, which made him more susceptible to mechanical compression. He wrote that claimant's employment materially aggravated his condition and was a contributing cause, but he did not say that employment was the major contributing cause. The Board implied dissatisfaction with the lack of detail in the letters from Long and Nathan when it found that Ochoa's letter "is the first report that discussed in detail the interaction of claimant's neuropathy and his carpal tunnel syndrome." The Board could reasonably interpret the letters from Long and Nathan to be sufficiently indefinite that employer could continue to have a legitimate doubt about the cause of claimant's CTS.

Affirmed.

Cite as 118 Or App 348 (1993) February 24, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kenneth A. Tattoo, Claimant.

KENNETH A. **TATTOO**, Petitioner,
v.
**BARRETT BUSINESS SERVICE**, Respondent.
(WCB 90-08503; CA A74765)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 23, 1992.
Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.
Jaurene R. Judy, Portland, argued the cause for respondent. With her on the brief were Scott H. Terrall and Terrall & Associates, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

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**118 Or App 350>** Claimant seeks review of an order of the Workers' Compensation Board that set aside the referee's award of attorney fees and a penalty, that reinstated and upheld employer's denials of temporary total disability and of chiropractic treatment, and that reversed the referee's award of unscheduled permanent disability. We affirm.

The Board found that claimant injured his lower back on August 1, 1989. He filed a claim for a lumbosacral sprain, which employer accepted. After months of chiropractic therapy failed to relieve claimant's back pain, his treating physician performed an MRI test. The test revealed abnormalities that preexisted claimant's industrial injury.

On April 3, 1990, employer issued this denial:

> "Studies * * * indicate that you are suffering from a spleen condition which is not causally related to your industrial injury on August 1, 1989 * * *. Those studies also indicate that you do not have discitis or osteomyelitis, which are conditions that also would be unrelated * * *.
>
> "Therefore, * * * [we] must respectfully deny your request for temporary total disability as your condition for which you may be disabled is not causally related to your industrial injury * * *.
>
> "We will continue to monitor your claim relating to the accepted lumbosacral strain for benefits due."

Claimant requested a hearing on that denial on April 18, 1990.

On May 30, 1990, employer denied claimant's request for payment of chiropractic care:

> "Medical information received to date indicates that current chiropractic care is not reasonable and necessary, and does not result from the August 1, 1989 lumbosacral strain injury * * *. Therefore, [we] must respectfully deny current chiropractic care."

Claimant supplemented his earlier hearing request to also challenge this denial.

On July 5, 1990, a determination order awarded claimant temporary disability benefits through February 19, 1990, and 8 percent unscheduled permanent disability. **<118 Or App 350/351>** Employer's request for reconsideration of that determination order was denied, because claimant's request for hearing on the denial of chiropractic treatment was pending. Claimant requested a hearing seeking permanent partial disability benefits in addition to those awarded by the determination order. Employer mailed its cross request for a hearing on the determination order on Friday, August 3, 1990. The request was received by the Board on Monday, August 6, 1990. The hearing was held on October 22, 1990, and the record was closed on December 7, 1990.

First, claimant argues that the Board erred when it applied the 1990 amendments to the Workers' Compensation Act to the issue regarding employer's denial of chiropractic treatment, because claimant requested a hearing in April, 1990, and the amendments did not become effective until July 1, 1990. However, the amendments provide that the former law is not applicable unless a request for hearing was made before May 1, 1990, *and* the hearing convened before July 1, 1990.[1] *See Astoria Plywood v. Culp*, 115 Or App 737, 840 P2d 99 (1992). The hearing in this case was convened on October 22, 1990. The Board properly applied the 1990 amendments.

Second, claimant argues that the May denial of chiropractic care was impermissibly prospective. *See Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 781 P2d 1262 (1989). The Board ruled that employer's denial was not prospective. The denial is for "current chiropractic care." However, claimant points to testimony at the hearing by employer's claims examiner in which she said that she meant the denial to cover past treatment and treatment into the future and that she did not believe it would be necessary to issue subsequent denials for future treatment.

We hold that employers are bound by the express language of their denials and the testimony of the claims **<118 Or App 351/352>** examiner here is irrelevant. Our previous decisions about whether a denial is prospective in nature are consistent with this proposition. *See Boise Cascade Corp. v. Hasslen*, 108 Or App 605, 816 P2d 1181 (1991); *Green Thumb, Inc. v. Basl*, 106 Or App 98, 806 P2d 186 (1991); *Evanite Fiber Corp. v. Striplin, supra.* If we were to hold to the contrary, an employer could change what it had expressly said in a denial to the detriment of all parties who have relied on the language. The Board did not err.

Third, claimant argues that the Board erred when it held that employer's failure to pay the temporary disability benefits within 30 days of the determination order was not unreasonable. Claimant seeks a penalty and/or award of attorney fees under ORS 656.210(1)(a) or ORS 656.382(1). The Board held that, because the 30th day from July 5, 1990, was August 4, 1990, and employer had mailed its request for hearing on Friday, August 3, 1990, it was reasonable for employer to believe that it had properly appealed the determination order and that it was not required to pay the benefits that had been ordered.

Before the 1990 amendments to the Workers' Compensation Law, ORS 656.313(1), the filing of an appeal did not stay payment of compensation. ORS 656.313(1)(a) now provides, in part:

> "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; and
>
> "(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed."

Claimant argues, and the Board agreed, that ORS 656.313(1)(a) is inapplicable, because no reconsideration order was issued in this matter. However, as the Board noted, employer was faced with

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[1] Oregon Laws 1990 (Special Session), chapter 2, section 54 provides:

"(1) [T]his 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of the date of injury * * *.

"(2) Any matter regarding a claim which is in litigation * * *, 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.)

In *SAIF v. Drews*, 117 Or App 596, ___ P2d ___ (1993), we held that, in order to shift responsibility to a subsequent employer under ORS 656.308(1), the first employer has the burden to establish that the claimant experienced a new injury at the subsequent employment. That is established if it is shown that the subsequent incident is a material contributing cause of the claimant's disability or need for treatment. Here, the Board found that the 1984 incident, after Smurfit became self-insured, was a new injury. Smurfit does not dispute that finding. The Board also said that

> "there may be a dispute about whether claimant's 'knee condition' as it existed on June 15, 1988, when surgery was recommended * * * was related to the * * * 1984 injury."

It held, however, that, because the 1984 injury was a new injury, under ORS 656.308(1), Smurfit, as a self-insured employer, was required to "process all *further* compensable medical services and disability involving claimant's left knee 'condition' as a part of that new injury claim." (Emphasis Board's.)

Smurfit contends that the Board erred because, before assigning Smurfit responsibility for the claim, it failed to determine that the need for surgery is related to the 1984 injury.

ORS 656.308(1) is presumably intended to simplify the processing of claims involving multiple employers or insurers and successive compensable injuries involving the same condition or body part. We conclude that, when benefits are sought for "further compensable medical services and disability subsequent to a new injury," ORS 656.308 is applicable if it is determined that the "further" disability or treatment for which benefits are sought is compensable, *i.e.*, that it is materially related to a compensable injury, and that it involves a condition that has previously been processed as a part of a compensable claim. Responsibility is then assigned **<118 Or App 371/372>** to the employer or insurer with the most recent accepted claim for that condition.

By accepting the claim, EBI has conceded that the surgery is materially related to the 1977 injury and, therefore, compensable. Smurfit also concedes that the surgery is compensable. The remaining question for the Board to decide is whether the surgery involves the same condition as was determined to be compensable in either 1977 or 1984. If it does, then either EBI or Smurfit, the one with the most recent accepted claim for the condition, must process the claim pursuant to ORS 656.308(1). If it does not involve the same condition, then the statute is inapplicable, and the claim should be processed without regard to it.

Reversed and remanded for reconsideration.

Cite as 118 Or App 373 (1993) March 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kim S. Jeffries, Claimant.

**CONAGRA, INC.**, Petitioner,
v.
KIM S. **JEFFRIES**, Respondent.
(90-05652; CA A74913)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 23, 1992.
Karen O'Kasey, Portland, argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt, Portland.
Max Rae, Salem, argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Reversed and remanded for assessment of a penalty on benefits due on date
*Leeson, J., *vice* Buttler, J., retired.

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**118 Or App 375>** Employer seeks review of an order of the Workers' Compensation Board assessing a penalty for its unreasonable denial of a claim of 25% of compensation due at the time of the hearing. We reverse the Board; we write to clarify that, in this case, the penalty is to be assessed on all compensation due at the time the denial was withdrawn.

Claimant injured his back in December, 1989. As a result of the injury, he had surgery to repair a herniated disc in January, 1990. Employer denied the claim in April, 1990. Subsequent to the hearing, but before the referee had issued an order, the parties settled the claim and employer agreed to process it. The parties stipulated that they would submit to the referee the question of whether claimant was entitled to a penalty under ORS 656.262(10) for employer's unreasonable denial of the claim. The referee found that employer had acted unreasonably and ordered that it pay a 25 percent[1] penalty based on unpaid medical services due as of the date of the denial. The Board affirmed the referee, but in the "opinion" portion of the order it stated that the penalty should be assessed on compensation due as of the date of the hearing.

ORS 656.262(10) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

Employer concedes that its denial of the claim was unreasonable and that "amounts then due" under ORS 656.262(10) are amounts due when the denial is set aside. *See Weyerhaeuser v. Knapp*, 100 Or App 615, 788 P2d 462 (1990). It contends, however, that at the time of the stipulation withdrawing the denial of the claim, there were no amounts due. Employer argues that, because no medical benefits are due before the claim is denied, ORS 656.262(6), and because a **<118 Or App 375/376>** denial terminates any obligation to make further payments on the claim, ORS 656.262(2), its obligation to pay benefits did not begin until *after* the stipulation withdrawing the denial.

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[1] The referee's opinion concludes that claimant is entitled to a 24 percent penalty; the order assesses a penalty of 25 percent. The Board affirmed the order and the order controls.

an array of temporary administrative rules to interpret in order to decide whether it could withhold payment. OAR 436-60-150(1) said that benefits <118 Or App 352/353> falling due on a weekend were payable on the working day before the weekend. However, OAR 436-60-150(6)(c) provided that permanent disability benefits were due no later than the 30th day *after* the date of any determination order awarding such compensation unless the order was appealed.[2]

The Board reasoned that, inasmuch as the 30th day was Saturday, August 4, 1990, it was reasonable for employer to conclude that it was not required to pay the award under the rules, because it believed that it had appealed the order on the 29th day. In fact, the request was not filed, according to the provisions of OAR 438-05-046(1)(b), until 32 days after the determination order. Nevertheless, the Board concluded that its inquiry was not whether employer had filed the request timely, but whether employer was reasonable in believing that it had done so, thereby abating the obligation to pay permanent partial disability.

Whether a delay in paying compensation is unreasonable under ORS 656.382(1) and ORS 656.262(10) involves both legal and factual questions. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 763 P2d 408 (1988). The correct legal inquiry is whether the employer had a legitimate doubt as to its liability. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the employer. If the Board uses the correct legal standard, then we review its finding about reasonableness for substantial evidence. 93 Or App at 592; ORS 183.483(8)(a). Although the Board did not use the term "legitimate doubt" in its opinion, the context of its analysis indicates that it applied the proper legal standard. Because there is substantial evidence to support the Board's findings, we affirm on that issue.

Finally, claimant argues that the April denial constituted a denial of a previously accepted condition while the claim remained open. Once an employer accepts a claim, it must pay compensation due on the claim. *Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983). However, an employer <118 Or App 353/354> may issue a partial denial of temporary benefits for an unrelated condition while an accepted claim is in open status. *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988); *see also Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 802 P2d 709 (1990), *rev den* 311 Or 261 (1991).

The Board found that employer accepted a claim of lumbosacral strain and that that acceptance did not include the abnormality claim, a separate condition not demonstrated to be a symptom of the strain.[3] Employer's denial is expressly limited to claims arising from claimant's spleen condition. Furthermore, it expressly reserved the right to consider benefits related to claimant's accepted lumbosacral injury. The Board did not err in holding that employer's denial was procedurally proper.

Affirmed.

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[2] Temporary rule OAR 436-60-150(6)(c) was revised in 1992 to provide that the appeal must be pursuant to ORS 656.313. This provision was not in effect at the time of this proceeding. Therefore, we do not consider it.

[3] In *Georgia-Pacific v. Piwowar, supra,* the court held that the employer could not partially deny benefits relating to ankylosing spondylitis when it had accepted a claim for a "sore back," because the claim was a symptom of the disease, not a separate condition. The court provided an example of a separate condition:

> "If, for example, Georgia-Pacific accepted a claim for 'lumbosacral strain,' which was one of the original diagnoses of claimant's condition, that acceptance would not include ankylosing spondylitis, since those are two separate infirmities (unless of course one is merely a symptom of the other)." 305 Or at 501.

Cite as 118 Or App 368 (1993) March 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Armand J. DeRosset, Claimant.

**SMURFIT NEWSPRINT**, Petitioner,
v.
ARMAND J. **DEROSSETT**, Respondent.
(90-11927; CA A74998)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 21, 1992.
Jerald P. Keene and Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland, filed the brief for petitioner.
Amy Kent, Portland, argued the cause for respondent. With her on the brief were Charles S. Tauman and Bennett & Hartman, Portland.
Before Richardson, Presiding Judge, and Rossman and Deits, Judges.
ROSSMAN, J.
Reversed and remanded for reconsideration.

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**118 Or App 370>** Smurfit Newsprint, a self-insured employer, seeks review of an order of the Workers' Compensation Board holding that it must process claimant's request for knee surgery. We reverse and remand for reconsideration.

Claimant suffered a compensable knee injury in 1977, while working for Smurfit, then insured by EBI.[1] He had surgery to repair a tear of the lateral meniscus. The claim was closed with an award of time loss and permanent partial disability. Claimant again injured his knee in 1984, while working for Smurfit, which had apparently become self-insured.[2] A claim for the injury, which was listed on the claim form as involving only a burn to the knee, was accepted and processed by Smurfit, as self-insured. As a part of the 1984 claim, Smurfit paid benefits for treatment of a knee strain. In the litigation of this claim, a question arose concerning whether the knee strain had been accepted as a part of the 1984 claim. The Board found that it had not been; it treated the 1984 knee strain as a new claim and found that it was compensable. Smurfit does not challenge that determination.

In 1988, claimant's doctor recommended a total left knee replacement. EBI, as Smurfit's insurer at the time of the 1977 injury, authorized knee replacement surgery and requested that the Board reopen the 1977 claim on its own motion. The Board did so. Claimant requested a hearing, contending that the 1988 surgery should not have been processed under the Board's own motion as a reopening of the 1977 claim, but rather as an aggravation of the 1984 injury. Smurfit denies that the surgery is related to the 1984 injury.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the **<118 Or App 370/371>** 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."

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[1] The Board's order says that claimant worked for Publishers Paper Company, insured by EBI, at all relevant times. At oral argument, claimant's attorney advised the court that claimant has always worked for "Smurfit/Publishers Paper Company." We assume that Smurfit and Publishers Paper are one in the same, that Smurfit was insured by EBI at the time of the 1977 injury, and that it later became self-insured.

[2] We say "apparently," because it is not clear from the record, briefs or the Board's order when Smurfit became self-insured.

Employer's argument begs the question. Although, as a procedural matter, an employer is not required to pay medical benefits before or after it denies a claim, if it is subsequently determined that the claim was improperly denied, any benefits that become due as a result of the setting aside of the denial are considered to be due as of the date the denial is set aside. At the time of the stipulation, claimant had undergone surgery for his compensable claim. Employer does not contend that that medical service was not compensable; accordingly, payment for the surgery was an amount due at the time of the stipulation setting aside the denial, and the Board properly assessed a penalty. The Board erred, however, in holding that the penalty was to be assessed on amounts due as of the date of the hearing, in view of the fact that the denial was not set aside at the hearing, but by stipulation subsequent to the hearing.

Reversed and remanded for assessment of a penalty on benefits due on date of withdrawal of denial.

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Cite as 118 Or App 456 (1993) March 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

**CENTRAL BLUEPRINT CO.**, INC., Petitioner,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, SAFECO INSURANCE COMPANY OF AMERICA and DEPARTMENT OF INSURANCE AND FINANCE, Respondents.
(90-07-024; CA A71605)

Judicial Review from Department of Insurance and Finance.

Argued and submitted June 29, 1992.

David O. Wilson, Eugene, argued the cause for petitioner. With him on the brief was Employers Defense Counsel, Eugene.

Gordon Welborn, Lake Oswego, argued the cause and filed the brief for respondent Safeco Insurance Company of America.

John T. Bagg, Assistant Attorney General, Salem, waived appearance for Department of Insurance and Finance.

No appearance by respondent National Council on Compensation Insurance.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

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**118 Or App 458>** Petitioner seeks review of a Department of Insurance and Finance (DIF) order requiring it to pay an additional workers' compensation premium to its carrier, respondent Safeco. The issue is whether certain payments to employees constituted wages or unanticipated bonuses or profit sharing. We affirm.

Safeco's premium is calculated from petitioner's payroll. The Basic Manual for Workers' Compensation and Employers Liability Insurance (Basic Manual)[1] excludes from remuneration

> "bonus pay which is not anticipated under the contract of employment and which is paid at the sole discretion of the employer, [and] amounts payable under profit sharing agreements * * *."

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[1] Respondent National Council on Compensation Insurance (NCCI) is an authorized workers' compensation rating organization. ORS 737.350 et seq. It promulgates the Basic Manual to identify the employee remuneration on which its member insurers calculate their premiums.

On May 30, 1990, Safeco audited petitioner's payroll and assessed an additional premium for bonus payments to Ronald Smith and Donald Smith between April 1, 1989, and March 31, 1990. Petitioner argued that the payments were properly excluded as unanticipated bonus payments or as profit sharing. DIF disagreed and sustained the assessment. Petitioner contends that no substantial evidence supports DIF's findings that the payments were not unanticipated bonuses or profit sharing, and that the order is inadequate for review because it fails to explain how DIF's findings lead to its conclusions.

Petitioner began business in 1972 as a partnership owned by Margaret and Wesley Smith. It was incorporated at a later date and Wesley became president. In 1979, the corporation authorized Wesley to pay performance bonuses to six key personnel, subject to adequate available funds. The key personnel consisted of his wife, Margaret, his children, Ronald Smith, Donald Smith and Sheryl McCoy, and two non-family members. From 1980 to 1986, petitioner paid between $2,000 and $4,000 in bonuses to each of between three and six workers. In 1981, 1982 and 1983, it paid no **<118 Or App 458/459>** bonuses. After Wesley died in 1987, petitioner's board of directors consisted of Margaret, who was president, Ronald, Donald and Sheryl. Beginning in 1987, petitioner paid to each, Margaret, Ronald and Donald, bonuses of $10,000 in 1987, $30,000 in 1988 and $50,000 in 1989. No other employees received bonuses in those years. The 1989 payments to Ronald and Donald are in dispute in this proceeding. DIF ruled that the issue was whether petitioner intended the payments to be an unanticipated bonus or profit sharing, and that petitioner failed to carry its burden on that issue. Petitioner offered no document, such as an employment contract, to corroborate its argument that the bonuses were unanticipated. The 1989 bonuses exceeded the salaries of Ronald and Donald. Petitioner's bonus policy was designed to reward and provide incentives to those persons most responsible for its success. Margaret testified that she intended to pay bonuses to "the ones that worked the hardest and did the most, which * * * turned out * * * to be family members[;] it's just a profit sharing type thing." The pattern of bonus payments shows that Ronald and Donald were consistently productive workers. Substantial evidence supports DIF's finding that the 1989 bonuses were anticipated.

Petitioner's bonus policy was not an agreement with employees, so the bonuses were not amounts payable under a profit sharing agreement. Moreover, employee productivity, not petitioner's profitability, determined whether petitioner paid bonuses. Substantial evidence supports DIF's finding that the 1989 bonuses were not amounts payable under a profit sharing agreement.

In response to petitioner's argument that the order is inadequate for review, respondent contends that nothing requires DIF to provide an explanation of the reasons why its findings caused it to reach its conclusions. That is incorrect for the reasons stated in *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975):

> "If there is to be any meaningful judicial scrutiny of the activities of an administrative agency--not for the purpose of substituting judicial judgment for administrative judgment but for the purpose of requiring the administrative agency to demonstrate that it has applied the criteria prescribed by statute and by its own regulations and has not acted arbitrarily or on an ad hoc basis--we must require that its order **<118 Or App 459/460>** clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes. Brevity is not always a virtue. The less circumscribed an agency is by the legislative grant of power to it and by its own regulations augmenting that grant, the more detailed and precise its explanation of its actions exercising the powers granted to it must be."

However, DIF's order does not lack adequate reasoning. Petitioner's evidence was equivocal at best and DIF committed no error.

Affirmed.

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