VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 46

(Pages 1-674)

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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.

JANUARY-MARCH 1994

Van Natta's Workers' Compensation Reporter is published quarterly by the editors, Robert Coe and Merrily McCabe. A one-year subscription costs $300 for the four quarterly volumes; a bi-monthly update service is available for an additional cost of $180. All subscription, billing, editorial and similar correspondence should be addressed to: The Editors, *Van Natta's Workers' Compensation Reporter,* 1017 Parkway Drive NW, Salem, Oregon 97304. (503) 362-7336 or (503) 585-5173. All requests for permission to make any otherwise infringing use of all or any part of this publication, including photocopying and copying for use with electronic media, should be addressed to the editors.

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CITE AS

46 Van Natta ____ (1994)

In the Matter of the Compensation of
BURGESS R. BALLER, Claimant
WCB Case No. 92-15749
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

The SAIF Corporation requests review of Referee Livesley's order that set aside its June 3, 1992 Notice of Closure as prematurely issued. SAIF contends that the Referee erred in finding the claim prematurely closed since neither party raised that issue at the hearing. On review, the issues are the hearing procedures and the extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the claim had been prematurely closed and set aside the June 3, 1992 Notice of Closure. On review, SAIF contends that the premature closure issue was not properly before the Referee. We agree.

Neither party raised the issue of premature closure at hearing. The sole issue before the Referee was the extent of unscheduled permanent disability. (Tr. 1-2). We have previously held that referees should not decide issues not properly before them. See Michael B. Petkovich, 34 Van Natta 98 (1982); Theodore W. Lincicum, 40 Van Natta 1760, 1762-63 (1988); Jimmy L. Massey, 44 Van Natta 436 (1992). Accordingly, since neither party contended that the claim was prematurely closed, we reverse the Referee's order and reinstate the June 3, 1992 Notice of Closure. Inasmuch as the record is completely developed concerning the extent of claimant's unscheduled permanent disability, we proceed to address that issue.

The applicable standards are those contained in WCD Admin. Order 6-1992 which was in effect on the date of the June 3, 1992 Notice of Closure.

Here, as the Referee noted, the record contains no persuasive evidence of measurable impairment under the standards. The only evidence of impairment is contained in a physical therapy report. Since the attending physician has not concurred with the physical therapist's report, it may not be used to rate claimant's impairment. ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 1799 (1991); see also Timothy J. Smith, 44 Van Natta 2246 (1992).

Because there is no evidence of measurable impairment under the standards, claimant has not established entitlement to an award of unscheduled permanent disability. OAR 436-35-270(2). However, inasmuch as the insurer has not requested a reduction in the 20 percent unscheduled permanent disability award granted by the Notice of Closure (and affirmed by the Order on Reconsideration), we do not alter it.

ORDER

The Referee's order dated March 24, 1993 is reversed. The June 3, 1992 Notice of Closure and the December 3, 1992 Order on Reconsideration are reinstated and affirmed.

Board Member Gunn dissenting.

Based on the language of ORS 656.283(7), I would affirm the Referee's order which found the claim prematurely closed.

As amended by the 1990 legislation, ORS 656.283(7) provides, in part: "If the referee finds that the claim has been closed prematurely, the referee shall issue an order rescinding the determination order or notice of closure." (Emphasis added). By its plain language, this statute gives referees authority to, on their own initiative, rescind Determination Orders or Notices of Closure, if the referee determines that the claim has been prematurely closed. Applying amended ORS 656.283(7) to this case, I would find that the Referee properly addressed the premature closure issue. Because I believe that the Referee's order should be affirmed, I respectfully dissent.

In the Matter of the Compensation of
LESLIE R. LEDFORD, Claimant
WCB Case No. 92-10065
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mills' order that affirmed a Director's order that found that claimant was not eligible for vocational assistance. On review, the issue is vocational assistance. We modify.

FINDINGS OF FACT

Claimant began working for the employer on February 20, 1991 as a lead concrete worker. Claimant was hired as a permanent full-time employee.

Claimant sustained a compensable injury on March 14, 1991, approximately 3 1/2 weeks after he started working.

At the time of his injury, claimant was working 8 hours a day, 5 days a week for $8.00 per hour. (Tr. 4, 6).

Based on a conversation with the claim examiner and the employer's personnel manager, the insurer's rehabilitation consultant concluded that claimant's employment was temporary. Accordingly, the insurer determined that claimant was ineligible for vocational assistance on the ground that, based on claimant's average wages as a temporary worker, claimant did not have a "substantial handicap to employment."[1] (Ex. 12). Claimant requested Director review of the insurer's decision.

After conversing with two employer representatives, the vocational consultant with the Rehabilitation Review Unit concluded that claimant's job was not guaranteed and that claimant was subject to layoffs. The Director disagreed with the insurer's position that the work in question was temporary. However, the Director found that claimant's job at injury was seasonal in nature, and relied on OAR 436-120-025(1)(b) to calculate claimant's suitable wage.

Because claimant did not collect unemployment benefits, the Director calculated an average weekly wage based on claimant's total earnings for the 52 weeks preceding his injury. Specifically, the Director divided claimant's total income for that period by 52, and divided the quotient by 40. That calculation resulted in a base wage of $1.03 per hour based on a full-time work week. Because suitable employment was available to claimant at 80 percent of that base wage, the Director concluded that claimant was not entitled to vocational assistance.

Claimant appealed the Director's order to the Hearings Division. A full evidentiary hearing was held on October 22, 1992.

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[1] "Substantial handicap to employment" for the purposes of determining eligibility for vocational assistance means "the worker, because of the injury, lacks the necessary physical capacity, knowledge, skills and abilities to be employed in suitable employment." ORS 656.340(6)(b)(A); OAR 436-120-005(10).

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.340, a worker is eligible for vocational assistance if the worker cannot return to his prior employment or other suitable employment. The parties agree that claimant will not be able to return to his prior employment. However, the Director found that claimant was able to return to suitable employment. Accordingly, claimant was disqualified from vocational assistance on that basis.

Because he concluded that the evidentiary record made at hearing supported the Director's findings, the Referee found that the Director did not abuse his discretion in concluding that claimant was not hired for permanent employment. The Referee, therefore, did not disturb the Director's order.

ORS 656.340(6)(b)(B)(iii) provides that employment is not "suitable employment" unless that employment "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)(a)(A) provides that "[f]or other than full time permanent employment, suitable wage is determined as described in OAR 436-120-025." The relevant portions of OAR 436-120-025(1)(b) provide:

> "(1) For the purpose of establishing a base wage from which to calculate a suitable wage when a worker's job at the time of injury is other than a full-time permanent job, the following standards apply:
>
> (b) Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at full time rate to establish the base wage."

Claimant's employment at injury was as of a lead concrete worker. The Director, apparently concluding that claimant's job at injury was other than full-time permanent, found the job at injury seasonal in nature. The Director then applied OAR 436-120-025(1)(b) to determine claimant's suitable wage, and concluded that suitable employment was available to claimant at that wage. (See Ex. 15).

Claimant contends that the Director erroneously relied on OAR 436-120-025(1)(b) to calculate his suitable wage. Specifically, claimant argues that the Director abused his discretion. See ORS 656.283(2)(d); John R. Coyle, 45 Van Natta 325, 327 (1993). Thus, the determinative issue for claimant's entitlement to vocational assistance is whether his at-injury employment as a lead concrete worker was permanent.

Relying on Lasley v. Ontario Rendering, 114 Or App 543 (1992), the Referee determined that his role in reviewing the Director's order was to determine the historical facts relevant to the dispute and then make findings of ultimate fact to determine whether the Director's order was subject to modification, pursuant to ORS 656.283(2). Applying this procedure, the Referee found that the job claimant was hired to perform was not a permanent position, because such jobs with the employer were subject to regular layoffs and a layoff which could have affected claimant occurred shortly after his injury. The Referee determined that the facts established at hearing supported the Director's decision, and therefore, the Referee lacked the authority to modify the Director's order.

Subsequent to the Referee's order, the Supreme Court in Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993) explained the scope of a referee's review of a Director's order. In Colclasure, the Director determined that the claimant was ineligible for vocational assistance, without having developed an evidentiary record by holding an evidentiary hearing. On review of the referee's order, which reversed the Director's order, we held that the referee was not permitted to find facts in relation to a review to determine eligibility for vocational services, and that an error of fact could not serve as a basis in itself for modifying the Director's decision under ORS 656.283(2). Richard A. Colclasure, 42 Van Natta 2454 (1990).

The Court of Appeals affirmed our decision. Colclasure v. Washington County School Dist. No. 48-J, 117 Or App 128 (1992). The Supreme Court reversed, stating that the provisions of ORS 656.283 contemplate, at a minimum, an opportunity to be heard, an opportunity to present and rebut evidence,

and a reviewable record. The Court reasoned that where the Director informally investigates and issues an order,[2] the referee's role is to conduct a hearing at which the parties develop a record; on the basis of that record, the referee finds the facts from which to conclude whether, among other things, the Director's decision survives review. The Board then reviews under ORS 656.283(2) upon the record developed before the referee. Colclasure v. Washington County School Dist. No. 48-J, supra.

In accordance with 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 only if it:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon lawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

In this case, the Director conducted an informal review. Claimant requested a hearing wherein the parties developed a record before the referee. On the basis of that record, the Referee found that claimant was not hired to perform permanent employment. Based on these findings, the Referee concluded that the Director's decision neither violated a rule or statute nor evidenced an abuse of discretion. Because we disagree with the Referee's findings of fact, we reach a different conclusion.

In deciding whether or not to apply OAR 436-120-025(1)(b) the crucial question is whether or not claimant's employment is properly considered permanent full-time work. This is a factual issue.

Claimant testified that at the time of hire it was his understanding that the position was permanent in that he was hired for a 40 hour work week at $8.00 an hour. (Tr. 4-8). He was not informed it was for a one time project or series of short term projects. Nor was he informed that his employment would come to an end on a date certain. Although after he was hired he was told of an impending cut back, he was not told that as a result he would be laid off. (Tr. 10).

The insurer's rehabilitation consultant concluded that claimant's employment was "temporary." This conclusion was based on a conversation with the claim examiner and the employer's personnel manager. The consultant testified that these individuals told her that claimant's employment was not guaranteed, and that claimant was subject to layoffs. (Tr. 14-15). However, just because claimant's employer did not promise claimant lifetime employment or offer "iron-clad assurances" that claimant would be spared in the event of a layoff, does not mean his job was not permanent full-time employment. Few of us are so fortunate that our jobs are "guaranteed" or otherwise "immune" from the vicissitudes of the economy, with its attendant layoffs, cut backs, and reduced hours. The fact such assurances were not made to claimant does not inextricably lead to the conclusion his position as a lead concrete worker is temporary.

The vocational consultant at the Director's rehabilitation review unit, on the other hand, reached a different conclusion. Based on conversations with two employer representatives, she found claimant's employment to be "seasonal." The consultant testified that in deciding whether or not to apply OAR 436-120-025(1)(b) she considered the pattern of employment at claimant's at injury job. (Tr. 30-36). She specifically relied on three findings: (1) the employer's pattern of employment for new employees was frequent layoffs; (2) at the time of hire there was no guarantee of permanent full-time work; and (3) that a layoff was imminent for claimant. (Tr. 35-36).

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[2] The Court also stated that a different result would have been obtained had the Director conducted a contested case hearing, made a record, entered findings of fact, and explained why those facts led to the conclusion that he reached. Colclasure v. Washington County School Dist. No 48-J, supra.

Whether claimant would have been laid off is speculation. The fact remains that claimant worked a 40 hour work week continuously until he was injured. There were no periods of unemployment. Although the employer may have been planning to layoff employees, the evidence is not persuasive that claimant would have, in fact, been laid off even if he had not been injured.

We find the most persuasive evidence was the testimony provided by claimant. Review of the record indicates claimant was a credible and reliable witness. We are also impressed by the fact he was the only individual to testify who had first hand knowledge or information of the arrangement or employment circumstances under which claimant was hired. No employer representative testified. Consequently, we find that the best evidence on this issue is claimant's credible testimony. Therefore, based on the evidence, we are persuaded that claimant was hired as a full-time permanent employee.

Given the fact claimant was a permanent full-time employee, we hold that the Director erred by applying OAR 436-120-025(1)(b) to calculate claimant's base wage. In other words, the factual situation in this case did not warrant the application of OAR 436-120-025(1)(b). Therefore, we conclude that the Director violated ORS 656.340 by relying on OAR 436-120-025(1)(b) to determine claimant's suitable wage. See ORS 656.283(2)(a). Instead, we find claimant's base wage from which to calculate a suitable wage to be the "at-injury" wage of $8.00 an hour as a lead concrete worker.

Consequently, using a base wage of $8.00 an hour to calculate suitable employment, claimant would have a substantial handicap to employment. (See testimony of Nancy Bieber, vocational consultant with the Rehabilitation Review Unit, Tr. 31-32). Therefore, we find the eligibility prerequisites of ORS 656.340 have been satisfied. See ORS 656.340(6)(a) & (b)(B)(iii); OAR 436-120-005(6)(a)(A); OAR 436-120-005(10). Accordingly, because the Director's order countermands eligibility, the order must be modified. ORS 656.283(2). Specifically, we modify the Director's order to direct the insurer to provide claimant the vocational assistance he would receive based on this at-injury work as a lead concrete worker. See Erwin L. Farmen, 45 Van Natta 463 (1993).

ORDER

The Referee's order dated November 10, 1992 is modified. The Director's order is modified to direct the insurer to provide claimant the vocational assistance he would have received based on his at-injury work as a lead concrete worker consistent with this order. Therefore, the claim is remanded to the insurer for further action consistent with this order.

In the Matter of the Compensation of
LORA L. PITTMAN, Claimant
WCB Case No. 92-12453
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Daughtry's order which found that claimant was barred by the doctrine of res judicata from litigating the compensability of her claim for thoracic outlet syndrome. On review, the issues are the preclusive effect of a stipulation on the claim for thoracic outlet syndrome and, if claimant is not precluded, compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On July 15, 1991, claimant and the SAIF Corporation entered into a stipulation that provided in relevant part:

> "Claimant filed a claim for an alleged injury to her wrists, arms and neck, occurring on or about October 15, 1990. The claim was denied by Notices of denial dated February 13, 1991 and April 16, 1991. Thereafter, claimant Requested a Hearing raising the issue(s) of compensability, responsibility and SAIF Corporation's denials dated February 13, 1991 and April 16, 1991.

"NOW, THEREFORE, IT IS HEREBY STIPULATED AND AGREED: 1) SAIF Corporation's denials of said claim are hereby set aside and the claimant's claim heretofore filed is accepted for the following condition(s): strain of the wrists, arms and neck.

1) claimant shall withdraw the Request for hearing on said claim and SAIF Corporation agrees to provide and the claimant agrees to accept such medical care and treatment and compensation for temporary total disability as provided by law. * * *

4) The Request for Hearing herein shall be dismissed with prejudice."

CONCLUSIONS OF LAW AND OPINION

Preclusive Effect of Stipulation

Claimant filed a claim for injury to her wrist, arms and neck based on work activities occurring October 26, 1990. In January 1990, claimant was diagnosed with thoracic outlet syndrome. On February 13, 1991, on behalf of Family Perm and Cut Center, SAIF disclaimed responsibility for, and denied compensability of, "neck, upper back, bilateral wrist strain, and thoracic outlet syndrome." (Ex. 13). On April 16, 1991, on behalf of Supercuts, SAIF denied compensability of "a claim for an alleged occupational disease to [claimant's] shoulders, arms, wrists and hands[.]" (Ex. 22A).

Claimant requested hearings from both denials, raising compensability and responsibility. On July 15, 1991, the parties entered into the above stipulation. After claimant again sought treatment for thoracic outlet syndrome, SAIF denied compensability.

The Referee concluded that claimant was precluded by res judicata from litigating the compensability of thoracic outlet syndrome. Apparently, the Referee based this conclusion on his reasoning that, by entering into the stipulation, the parties had not intended that thoracic outlet syndrome would be accepted and, therefore, such claim had been resolved.

Essentially, a party may not relitigate any issue resolved by a stipulation or DCS, since a party is bound by such agreement. Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993); Gilkey v. SAIF, 113 Or App 314, 316-17 (1992); International Paper Co. v. Pearson, 106 Or App 121, 124 (1991); Proctor v. SAIF, 68 Or App 333, 335 (1984). See Southwest Forest Industries v. Archer, 109 Or App 349 (1991); Wassen v. Evanite Fiber Corp., 117 Or App 246, 248 (1992). Cf. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). Consequently, we look only to the terms of the agreement to determine whether a party is precluded from litigating a particular issue.

We find that the agreement here has no effect on the resolution of the claim for thoracic outlet syndrome. The stipulation provided only that the parties agreed that SAIF's denials were set aside, a strain of the wrists, arms and neck was accepted, and claimant's request for hearing was withdrawn and dismissed with prejudice. Other than setting aside SAIF's February 13, 1991 denial of the thoracic outlet syndrome, the terms of the stipulation did nothing to resolve the claim for thoracic outlet syndrome. Furthermore, we note that the stipulation did not include an agreement to resolve all issues "raised or raisable". Inclusion of such terms would have reflected an intention on the part of the parties to dispose of all issues which could have been disputed at the time the parties entered into the stipulation, even if not expressly resolved by the agreement. See Safeway Stores, Inc. v. Seney, supra.

Having found that claimant is not precluded by the stipulation from litigating the compensability of her claim for thoracic outlet syndrome, we proceed to the merits.

Compensability

Claimant was first diagnosed with thoracic outlet syndrome by Dr. Jacobs, industrial medicine specialist, who examined claimant on referral from her prior treating physician, Dr. Neuberg. (Ex. 9-2). Dr. Jacobs also performed a nerve conduction study, which was normal. (Ex. 5). Dr. Jacobs did not attribute claimant's condition to her work activities. (Id.)

Claimant eventually sought treatment from Dr. Ellison, claimant's present treating orthopedic surgeon. He also diagnosed thoracic outlet syndrome based on claimant's history and clinical

examination. (Ex. 12-20). When claimant's symptoms continued to persist, Dr. Ellison referred claimant for an electrodiagnostic examination, which was normal. (Ex. 20-2). Dr. Ellison also referred claimant to Dr. Gerstner, thoracic and vascular surgeon. He concurred with the diagnosis of thoracic outlet syndrome. (Ex. 21-2). Both Dr. Ellison and Dr. Gerstner attributed claimant's condition to her work activities. (Exs. 22, 42).

Claimant also attended several independent medical examinations. The first, by Drs. Coletti, orthopedic surgeon, and Peterson, neurologist, disagreed that claimant had thoracic outlet syndrome and, instead, diagnosed "occupationally related upper extremity and cervical complaints." (Ex. 15-4). Dr. Rich, who conducted the next IME, also found no evidence of thoracic outlet syndrome. (Ex. 25-5). He diagnosed "overuse syndrome, neck, shoulders, and upper extremities." (Id.) Both panels found that the major contributing cause of claimant's condition was her work activities. (Exs. 15-4, 25-6).

Finally, Dr. Porter, professor of vascular surgery at OHSU, examined claimant. He reported finding no objective physical findings indicating thoracic outlet syndrome, concluding that claimant's history was more compatible with fibromyalgia syndrome. (Exs. 34, 38). Dr. Porter also found no known etiology for claimant's condition. (Id.)

Dr. Porter referred claimant to Dr. Mertens, neurologist, for examination. After performing a nerve conduction study, Dr. Porter also found no "clear evidence for classic neurogenic thoracic outlet syndrome." (Ex. 37-3). He diagnosed chronic tension headaches, chronic neck strain, and overuse syndrome. (Id.) Although indicating that claimant likely would become symptomatic if she returned to a work environment that required repetitive arm motions, Dr. Mertens did not provide an opinion regarding causation. (Id.)

We find that the preponderance of evidence establishes that, whether or not diagnosed as thoracic outlet syndrome, claimant's neck, shoulder and arm condition is compensable. The record shows that all physicians who examined and treated claimant addressed essentially the same complex of symptoms and that claimant's condition has not changed since November 1990, when she first sought treatment. The only opinions that do not support causation are those of Dr. Jacobs and Dr. Porter; however, we find that such opinions are overcome by the contrary opinions of Drs. Ellison and Gerstner, the treating physicians. See Weiland v. SAIF, 64 Or App 810 (1986). Furthermore, their opinions are supported by those of the independent medical examination panels. Consequently, we conclude that claimant proved the compensability of her neck, shoulder and arm condition. See ORS 656.802(2).

Claimant's attorney 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 claimant's attorney's services at hearing and on review regarding this case is $4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's and reply briefs), the complexity of the issues, and the value of interest involved.

ORDER

The Referee's order dated January 7, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing under the law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DIANNA E. STURGIS, Claimant
WCB Case No. 92-12815
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's pregnancy was the major contributing cause of her need for medical services and disability resulting from CTS. Thus, the Referee concluded that claimant's work activities were not the major contributing cause of her need for medical treatment and disability. We reverse.

To establish a compensable occupational disease, claimant must prove, by medical evidence supported by objective findings, that her employment conditions were the major contributing cause of her CTS. ORS 656.802(2) The "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). There is, however, a distinction between the cause of a disease and a predisposition to the development of that disease. Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993). A predisposition is a condition of special susceptibility to a disease, not a disease itself. Preston v. Wonder Bread, 96 Or App 613, rev den 308 Or 405 (1989).

In disputing that claimant's CTS is compensable, the insurer offers two theories on causation. The insurer first argues that claimant's carpal tunnel symptoms were caused by a predisposition to CTS due to congenital narrow carpal tunnel spaces.

Here, the opinions of Drs. Radecki, Button, and Cohen refer to claimant's possible predisposition to CTS. However, because the law provides that any such predisposition which claimant may have is not relevant to the compensability issue, we do not rely upon those portions of the doctor's opinions. See Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991); Portland Adventist Medical Center v. Buckallew, supra.

The insurer also argues that the fluid retention and resultant pressure on claimant's carpal tunnels during her third pregnancy, combined with her preexisting anatomy to cause her CTS. Relying on the opinions of Drs. Radecki and Button, the insurer asserts that claimant's wrist symptoms originated during the third trimester of her last pregnancy. The insurer contends that Drs. Radecki and Button support a finding that claimant's third pregnancy was a "greater causal factor than her work" in producing her CTS and resultant need for surgery.

Claimant contends that her CTS predated her third pregnancy. Relying on Drs. Wade and Cohen, claimant asserts that her CTS was caused by her work activity.

Dr. Wade, treating surgeon, opined that claimant's work activities over the years were the cause of her CTS and resultant need for surgery after the third pregnancy. He noted that claimant experienced carpal tunnel symptoms prior to her third pregnancy. Dr. Wade reported that claimant experienced physiological changes during her pregnancy and her carpal tunnel symptoms progressively worsened during that time. Dr. Wade also stated that after her pregnancy, claimant continued to experience persistent carpal tunnel symptoms. Dr. Wade noted that as a hair dresser, claimant "works with her [arms] out extended and uses a great deal of hand and finger motion in that position, which does prelude [sic] her to carpal tunnel syndrome." Dr. Wade opined that claimant's work activities significantly affected the onset of her carpal tunnel symptoms and resultant need for surgery.

We rely on the opinion of Dr. Wade. As the attending physician and surgeon, Dr. Wade was in the best position to evaluate claimant's condition. See Weiland v. SAIF, 64 Or App 610 (1982). Further, Dr. Wade demonstrated a thorough knowledge of claimant's work activities and history of her complaints. Moreover, Dr. Wade provided well-reasoned explanations to support his conclusion. Somers v. SAIF, 77 Or App 259, 263 (1986). Notwithstanding the fact that Dr. Wade's opinion does not contain "magic words," see McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we interpret his opinion to indicate that the work activities were the major contributing cause of claimant's CTS.

In addition, Dr. Wade's opinion is supported by Dr. Cohen, orthopedic surgeon. Dr. Cohen reported that claimant's carpal tunnel symptoms began approximately 7 years ago. Dr. Cohen opined that claimant had a predisposition of anatomical space in her carpal tunnel and the kind of work she performed aggravated her condition.

Moreover, Dr. Button is also supportive of Dr. Wade's opinion to the extent that he found that claimant had experienced periodic carpal tunnel symptoms for a number of years. In other words, Dr. Button's report indicates that claimant's CTS was of long duration and preceded her third pregnancy.

Finally, the facts support Drs. Wade and Cohen's opinions inasmuch as claimant had carpal tunnel symptoms before her third pregnancy and continued to have those symptoms at a disabling intensity post partum.

Dr. Wade found that claimant's work activities were the cause of her CTS and resultant need for surgery. Based on this evidence, we find that claimant has carried her burden of proof, establishing the compensability of her bilateral CTS. Therefore, we reverse the Referee's order.

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 $4,500, 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 appellant and reply briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 2, 1993 is reversed. The insurer's denial is set aside. The claim is remanded to the insurer for processing in accordance with the law. Claimant's attorney is awarded $4,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
BETTY BARNETT, Claimant
WCB Case No. 91-06319
ORDER ON REMAND
Robert G. Dolton, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Barnett v. SAIF, 122 Or App 279 (1993). The court has reversed our prior order that affirmed and adopted a Referee's order that upheld the SAIF Corporation's denial of claimant's low back strain injury claim. The Referee had concluded that SAIF's denial should be upheld because no physician had offered a medical opinion relating claimant's back condition to her work activities. Reasoning that this case did not require expert medical evidence to prove causation, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the exception of the first paragraph in that section. We add the following correction and supplementation.

On July 15, 1989, claimant suffered a prior compensable injury while working for her employer as a bartender. That day, she injured her back when she was lifting cases of beer. She experienced pain and spasms from the middle of her back to her beltline. Claimant's mid and upper low back was treated conservatively by Dr. Torkko with chiropractic adjustments, ultrasound, hot packs and ice packs and a back support. Claimant last sought treatment for that injury in August, 1989. She received no permanent disability award arising from that claim.

Claimant remained employed by her employer as a bartender. On March 21, 1991, while she was stocking and moving cases of beer, she felt something pull or tear in her back. The next morning, she reported the incident to her supervisor, who was the employer's manager.

Claimant presented at an emergency room the morning after the incident. She complained of low back and left leg pain and bilateral leg numbness.

Claimant treated with Dr. Cummings for the month following her work accident. During that time, claimant experienced lumbosacral and sacroiliac pain, and tenderness in the left sacral region. Cummings diagnosed low back or lumbosacral strain, and referred claimant to Dr. Ure, a back specialist. On May 5, 1991, Dr. Ure examined claimant, who gave a history of injuring her back while lifting beer cases at work. Ure noted that claimant had complaints of low back and left buttock pain and that she had right sacroiliac joint and right buttock tenderness.

ULTIMATE FINDING OF FACT

Claimant's work activities on March 21, 1991 were a material contributing cause of her low back disability and need for medical treatment.

CONCLUSIONS AND OPINION

CREDIBILITY

We adopt those portions of the Referee's Conclusions of Law and Opinion that determined that, based on demeanor, claimant was a credible witness. We also adopt the remaining portions of the Referee's conclusions concerning the other witnesses' credibility (particularly the finding that the employer's night bartender was not credible).

COMPENSABILITY

By adopting the order of the Referee, we concluded that claimant was required to submit expert medical evidence that her work was the cause of her low back condition. The Court of Appeals disagreed with us and concluded that, because this is not a complex case, expert medical testimony regarding the cause of claimant's low back condition was not required. Instead, the court listed the factors enumerated in Uris v. Compensation Department, 247 Or 420 (1967) for determining whether expert testimony of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the claimant promptly reports the occurrence to a supervisor; (4) whether the claimant was previously free from the disability of the kind involved; and (5) whether there is any expert testimony that the alleged precipitating event could not have been the cause of the claimant's disability. Barnett v. SAIF, supra, 122 Or App at 283.

Applying those factors, the court concluded that claimant need not introduce expert medical evidence to prove the cause of her low back strain. Consequently, the court has remanded for reconsideration concerning the compensability of claimant's injury claim.

To establish a compensable injury, claimant has the burden of proving that she sustained an injury that caused disability or need for medical services involving her low back, a material cause of which was the work incident on March 21, 1991. See ORS 656.005(7)(a); ORS 656.005(19); Mark N. Wiedle, 43 Van Natta 855 (1991). Applying that standard, we are persuaded that claimant has established the compensability of her injury claim. We base our conclusion on the following reasoning.

Claimant testified that she hurt her back when she lifted cases of beer at work. Claimant immediately told a customer that she had "pulled the heck out of [her] back." (Tr. 20.) The morning after the incident, claimant reported the accident to her supervisor and sought medical treatment for complaints of low back pain, spasms, left leg pain and bilateral leg numbness. Dr. Cummings diagnosed claimant with low back or lumbosacral strain and treated her accordingly. Dr. Ure, who was aware of claimant's on-the-job injury, examined claimant and found her to have tenderness in her right sacroiliac joint and buttock.

Although claimant has had previous back symptoms, she last sought treatment for those complaints in August 1989. Furthermore, according to the medical reports authored by Drs. Cummings and Ure, in addition to low back pain, her current condition involved left leg and left buttock pain, spasms, bilateral leg numbness, and sacroiliac and right buttock tenderness. The record does not establish that, prior to the March 21, 1991 injury, she experienced such complaints.

Finally, although no medical report expressly relates claimant's current disability to a March 1991 work injury, the court has ruled that such an omission is not determinative. Moreover, Dr. Ure renders his findings based on a history of a recent work injury. In doing so, he neither questions claimant's history nor suggests another cause of claimant's current condition.

Consequently, we find that claimant's medical records, coupled with her credible testimony, establish that her work was at least a material contributing cause of her current low back strain.[1] Therefore, her back strain is compensable.

Accordingly, on reconsideration, we reverse the Referee's order dated November 27, 1991. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

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[1] SAIF also argues that we should affirm the Referee's decision because claimant did not provide her physicians with complete medical histories. The court has already ruled that claimant was not required to submit expert medical evidence of causation. Furthermore, SAIF does not contest the fact that claimant's complaints are supported by objective findings. See ORS 656.005(7)(a); 656.005(19). In any event, we do not find SAIF's contention to be dispositive. Our conclusion finds further support in the fact that claimant received treatment for her July 1989 injury for only one month, her earlier claim resulted in no permanent disability award and claimant has continued to experience symptoms related to that earlier injury.

In the Matter of the Compensation of
PATRICIA L. FOSTER, Claimant
WCB Case No. 93-01427
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration that awarded 13 percent (41.6 degrees) unscheduled permanent disability for her low back. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

On June 23, 1991, claimant compensably injured her cervical and lumbosacral spine when she slipped on some ice in the employer's freezer. On September 18, 1991, Dr. Kaesche performed a right laminotomy and discectomy at L5-S1.

In February 1992, after completing an injured workers' rehabilitation program, claimant returned to modified work at the employer in a light duty position. (Ex. 15B).

In March 1992, claimant slipped and fell on some barbecue sauce at work, increasing her pain. In May 1992, Dr. Lorish, her attending physician, took her off work and prescribed physical therapy. (Ex. 15J).

On July 21, 1992, Drs. Marble, orthopedic surgeon, and Reimer, neurologist, performed an independent medical examination (IME). They declared claimant medically stationary and able to return to modified work. (Ex. 16). A physical capacities evaluation (PCE) found that claimant was capable of returning to sedentary work with modifications. (Ex. 17). Dr. Lorish concurred with the IME and PCE reports. (Ex. 18).

In August 1992, another physical capacities evaluation was administered, which was found invalid. (Ex. 19). In September 1992, Dr. Lorish released claimant to sedentary to light work, and approved a sedentary deli clerk job with restrictions. (Exs. 20 and 22). Claimant has not returned to work.

A Determination Order issued on October 8, 1992, awarding temporary disability and 13 percent (41.6 degrees) unscheduled permanent disability. (Ex. 23).

On December 22, 1992, Dr. Lorish examined claimant and made low back impairment findings. (Ex. 24).

Claimant requested reconsideration, raising the issue of the rating of impairment. (Ex. 25-2). Claimant did not disagree with the impairment findings, but rather provided Exhibit 24 to supplement the earlier information provided by the attending physician. (Ex. 25-1). No medical arbiter was requested or appointed.

A January 29, 1993 Order on Reconsideration affirmed the Determination Order in all respects. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contested adaptability and impairment, specifically the low back range of motion findings. Based on Raymond E. Mackey, 45 Van Natta 776 (1993), the Referee declined to consider adaptability because claimant failed to raise it in her request for reconsideration. Because claimant's disability was rated at the time of claim closure, the Referee also declined to consider Dr. Lorish's December 1992 impairment findings, since his report had been submitted after the date of claim closure.

In light of the holding in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), which issued subsequent to the Referee's order, we issued Darlene K. Bentley, 45 Van Natta 1719 (1993). In Bentley, we disavowed Mackey and held that a claimant may challenge non-impairment factors at hearing, even if no objection was made to those factors in the request for reconsideration. Also subsequent to the Referee's order, we held in Cynthia L. Luciani, 45 Van Natta 1734 (1993), that a medical report based on a post-closure examination by the attending physician could be considered by a referee in evaluating extent as long as the report is not subject to the statutory limitations concerning evidence that may be submitted at hearing by ORS 656.245(3)(b)(B), 656.268(7), or 656.283(7). See also Smith, supra.

If a medical arbiter is appointed, ORS 656.268(7) prohibits the admission of evidence developed after the medical arbiter's report. Scheller v. Holly House, 125 Or App 454 (1993); Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Furthermore, evaluation of the worker's disability by the referee shall be as of the date of the reconsideration order pursuant to ORS 656.268. See ORS 656.283(7); Smith, supra.

Exhibit 24 is a medical report by Dr. Lorish, claimant's attending physician, based on an examination that took place subsequent to claim closure, but prior to reconsideration. It consists of lumbar range of motion findings. Inasmuch as Dr. Lorish is claimant's attending physician, the limitation in ORS 656.245(3)(b)(B) is not applicable. Furthermore, because no medical arbiter was requested or appointed, the limitation of ORS 656.268(7) does not apply. Finally, because this report is based on claimant's condition prior to the date of the reconsideration order, it may be considered in accordance with ORS 656.283(7). Therefore, we consider this report in our evaluation of claimant's impairment. Cynthia L. Luciani, supra.

We accordingly evaluate claimant's disability as of the date of the reconsideration order and address the issue of adaptability, which was raised at hearing. Claimant contends that she is entitled to an increased unscheduled permanent disability award, based on these two factors. Claimant has the burden to prove the extent of disability resulting from her compensable injury or occupational disease. ORS 656.266. Unscheduled partial disability is rated based on the permanent loss of earning capacity. ORS 656.214(5).

Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f). This calculation is made by determining the appropriate values assigned by the standards to the worker's age, education (including skills), adaptability and impairment.

Claimant's claim was closed on October 8, 1992. Accordingly, we apply the standards effective March 13, 1992, as promulgated in WCD Admin. Order 6-1992. OAR 436-35-003(2) (WCD Admin. Order 93-056).

Impairment

Claimant contends that she has reduced range of motion in her low back. We agree.

Dr. Lorish made the following lumbar range-of-motion findings, based on use of the inclinometer. See OAR 436-35-360(1).

Flexion - 10 degrees for 10 percent impairment. OAR 436-35-360(19).

Extension - 3 degrees for 6.1 percent impairment. OAR 436-35-360(20).

Right lateral bending - 15 degrees for 2 percent impairment. OAR 436-35-360(21).

Left lateral bending - 15 degrees for 2 percent impairment. OAR 436-35-360(21).

For a total impairment value due to loss of motion as measured by inclinometer, the values are added for a total of 20.1 percent impairment in the low back. These values are then rounded to the nearest whole number, 20 percent. OAR 436-35-360(22) and 436-35-007(11). The total range of motion loss, 20 percent, is combined with (not added to) the total surgical impairment value of the same region, here 9 percent, for a diskectomy at L5-S1, for a total impairment rating for the low back of 27 percent. OAR 436-35-360(23).

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 (RFC) at the time of determination. OAR 436-35-310(1).

Claimant contends that her correct job title at the time of injury was that of a Stock Clerk, DOT #299.367-014, which is heavy work and has an SVP of 4, not a Deli Slicer, DOT #316.684-014, which is light work and has an SVP of 2.

Because the adaptability factor is based upon strength demands, we have found it reasonable to consider both claimant's job duties and the physical demands of her job in determining a proper DOT to be assigned to her job. See, e.g., Michele A. Montigue, 45 Van Natta 1681 (1993); Andrea M. Gildea, 45 Van Natta 2293 (1993).

Here, claimant's job title as a Deli Cutter-Slicer is classified as requiring light strength. DOT #316.684-014. The SCODDOT description of a deli slicer includes using a slicing machine or knives to slice meats and cheeses, stacking cut pieces on a tray or platter, weighing and wrapping sliced foods, and affixing a sticker showing the price and weight.

Claimant, who worked for a food store, testified that the job of Delicatessen-Goods Stock Clerk more accurately described her job at the time of injury. She explained that she worked as a night closer, which required her to spend most of her time restocking the delicatessen shelves for the people that opened up in the morning. Restocking merchandise displays is one part of the description of a Stock Clerk, DOT #299.367-014. However, even though she performed the job of restocking shelves, there is no evidence in the record regarding the weight claimant was required to lift while performing her job at the time of injury. Consequently, we conclude that claimant has failed to prove that her strength demand at the time of injury was greater than that specified by "deli cutter-slicer," which is light work. See Michele A. Montigue, supra; Andrea M. Gildea, supra.

Claimant's maximum RFC is her remaining ability to perform work-related activities despite impairment. OAR 436-35-270(3)(d). Dr. Lorish restricted claimant to lifting 10 to 15 pounds (Ex. 21), which is in the sedentary to light range. He also restricted claimant from bending and reaching, and she must alternate sitting and standing. (Ex. 22-1). For those workers who have a RFC established between two categories and also have restrictions, as here, the next lower classification shall be used. OAR 436-35-310(4). Thus, claimant's RFC is sedentary. Where claimant's prior strength is light and her RFC is sedentary, her adaptability factor is 3. OAR 436-35-310(3) and (4).

Age

The parties do not dispute the value of 0 for age.

Education

The parties do not dispute the education factor of 2.

Having determined each of the values necessary under the standards, we calculate claimant's unscheduled permanent disability. The sum of the value (0) for claimant's age and the value (2) for education is (2). The product of that value and the value (3) for claimant's adaptability is (6). The sum of that product and the value (27) for claimant's impairment is (33). That value represents claimant's unscheduled disability. OAR 436-35-280.

ORDER

The Referee's order dated May 4, 1993 is modified. In addition to the Order on Reconsideration, which awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability for the low back, claimant is awarded 20 percent (64 degrees) unscheduled permanent disability, for a total award for her low back condition of 33 percent (105.6 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
PENNY L. HAMRICK, Claimant
WCB Case Nos. 92-13017 & 92-04669
ORDER ON REVIEW
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys
Neil W. Jones, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Nichols' order that declined to award an assessed attorney fee for services at hearing. Fireman's Fund Insurance Companies cross-requests review of that portion of the Referee's order which: (1) set aside its denial of claimant's occupational disease claim for her right elbow condition; and (2) upheld Safeco Insurance Company's denial of claimant's claim for the same condition. On review, the issues are responsibility 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.

According to claimant's 801 forms with her employers, her hourly wage for each employment was $4.75. (Exs. 6, 10). In addition, claimant also received tips while working for Pizza Hut (Fireman's insured). (Tr. 10-11). Finally, claimant's hours for Pizza Hut eventually became full-time work. (Tr. 14).

CONCLUSIONS OF LAW AND OPINION

Responsibility

We affirm and adopt the Referee's Conclusions of Law and Opinion on the issue of responsibility, with the following supplementation.

On review, Fireman's contends that, because Safeco did not comply with the notice of disclaimer provisions of ORS 656.308(2), it cannot argue that responsibility lies with Fireman's insured. We disagree.

ORS 656.308(2) provides, in part, that "no employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer..." In the present case, however, claimant filed claims against both employers, and both employers issued responsibility denials. Consequently, because both employers were at hearing, neither Fireman's nor claimant were prejudiced by any failure of Safeco to comply with ORS 656.308(2). Therefore, we conclude that Safeco could deny responsibility on the ground that claimant's work with Fireman's insured caused her condition.

Attorney Fee/Hearing Level

Claimant filed an occupational disease claim for her right elbow condition with two employers. Fireman's Fund (as the insurer for Pizza Hut) denied responsibility for the claim. Safeco (as the insurer for Elmer's Pancake House) denied both compensability and responsibility. Shortly before the hearing, Safeco withdrew the compensability portion of its denial. The parties proceeded to hearing regarding the issues of responsibility, penalties, and attorney fees.

Claimant sought a carrier-paid attorney fee award under ORS 656.386(1) for her counsel's efforts in prompting Safeco's concession of compensability prior to the hearing. Relying on John L. Law, 44 Van Natta 1619 (1992), the Referee held that claimant was not entitled to such an award because a hearing had been held.

After further examination of the Board's holding in Law, we conclude that its reasoning was flawed. Specifically, we are not persuaded that the appellate decision on which Law was based (Multnomah County School District v. Tigner, 113 Or App 405 (1992)) compels the Law holding.

In Tigner, three carriers had denied responsibility for a claim. Only one carrier had also denied compensability of the claim. Prior to the scheduled hearing, the parties agreed that the carrier who had denied compensability could be dismissed as a party. Thereafter, the remaining carriers and claimant proceeded to hearing on the issue of responsibility.

The Tigner court reversed the Board's conclusion that claimant was entitled to a carrier-paid attorney fee under ORS 656.386(1), payable by the carrier found responsible for the claim. Reasoning that none of the carriers had denied compensability of the claim, the court held that claimant was not entitled to a carrier-paid attorney fee for the responsibility hearing. Such a holding was consistent with existing case precedent. See Mercer Industries v. Rose, 103 Or App 96, 98 (1991), rev den 311 Or 150 (1991); Hunt v. Garrett Freightliners, 92 Or App 40 (1988).

In reaching its conclusion, the court further noted that a "nonparticipating" carrier had denied compensability. Tigner, supra, n. 2, page 409. Nevertheless, since that carrier had been dismissed from the proceedings, the court determined that "claimant cannot bootstrap entitlement to insurer paid attorney fees on a nonparticipating insurer's denial of compensability." Id.

Finally, the Tigner court disagreed with the claimant's contention that he was entitled to a carrier-paid fee because his counsel had been instrumental in obtaining compensation for him. Noting that the statutory provision authorized a carrier-paid attorney fee if a hearing is not held, the court concluded that ORS 656.386(1) did not apply because a hearing had been held.

Relying on this latter reasoning by the Tigner court, the Board in Law held that a claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) when a "participating" carrier (i.e., the carrier remained a party to the hearing concerning the responsibility issue) rescinded the compensability portion of its denial prior to hearing. Although such a conclusion is consistent with the literal statement made by the Tigner court, the statement must be interpreted within the context of the particular facts on which the court based its opinion.

In other words, the precise holding of Tigner is that the claimant was not entitled to a carrier-paid attorney fee award under ORS 656.386(1) because no "participating" carrier to the proceeding had denied compensability of the claim. Granted, the Tigner court also rejected the claimant's entitlement to an attorney fee award based on the convening of a hearing. However, in light of its prior reasoning refusing to "bootstrap" the dismissed "nonparticipating" carrier's compensability denial into the proceeding, the court's rejection of the attorney fee request on "the holding of a hearing" theory was dicta.

The Board in Law chose to apply that dicta to a case where a "participating" carrier had rescinded the compensability portion of its denial prior to hearing. Based on the aforementioned analysis of Tigner, such a conclusion was erroneous.

Our reasoning is further fortified by the court's recent opinion in SAIF v. Allen, 124 Or App 183 (1993). The Allen court reversed a Board order which awarded a carrier-paid attorney fee under ORS 656.386(1) for prevailing against a carrier's "de facto" denial of medical bills without a hearing. Relying on Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the Allen court reiterated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." Furthermore, citing Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute."

Since the hearing in Allen pertained to the carrier's nonpayment of medical bills and because the compensability of her injury was never disputed, the court concluded that her attorney was not entitled to an attorney fee award under ORS 656.386(1). In reaching its conclusion, the Allen court further determined that the 1991 legislative amendment to ORS 656.386(1) (allowing for a carrier-paid attorney fee when an attorney has been instrumental in obtaining compensation for claimant without a hearing) did not provide an independent basis for an attorney fee award apart from the other requirements of the statute. In other words, the Allen court reasoned that the amendment merely established that attorney fees may be assessed if a hearing is not held, but that claimant must otherwise be entitled to such an award under the other provisions of the statute and applicable cases.

Here, it is uncontested that a "participating" carrier had denied the compensability of claimant's claim. Since that "participating" carrier rescinded that compensability denial prior to hearing, claimant's counsel is entitled to an attorney fee award under ORS 656.386(1) to be paid by that "participating" carrier for counsel's services in obtaining compensation for claimant without a hearing. Such a conclusion is not only consistent with the rationale expressed in Allen regarding the necessity of a denial of compensation for application of the statute, but it is also in accord with the precise holding in Tigner. Therefore, to the extent that our holding today is inconsistent with Law and its progeny, those decisions are disavowed.

Accordingly, we conclude that claimant is entitled to a carrier-paid attorney fee for her counsel's efforts in obtaining compensation for claimant without a hearing; i.e., the withdrawal of the compensability portion of Safeco's denial prior to hearing. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,500 is a reasonable assessed fee for claimant's counsel's pre-hearing services concerning the compensability issue. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the record, including the pre-hearing deposition), the complexity of the issue presented, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Attorney Fee/Board Level

According to claimant's 801 forms with her employers, her hourly wage for each employment was $4.75. (Exs. 6, 10). However, claimant's unrebutted testimony established that she also received tips while working for Pizza Hut (Fireman's insured) and that her hours for that employer eventually became full-time work. (Tr. 10, 11, & 14). In light of such circumstances, we conclude that because Fireman's cross-requested review, claimant's compensation was at risk of reduction if Safeco was found responsible for the claim. International Paper Company v. Riggs, 114 Or App 203, 206-07 (1992). Therefore, we conclude that claimant's attorney is entitled to a fee for services on review, payable by Fireman's.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $750 is a reasonable assessed fee for claimant's counsel's efforts on review regarding Fireman's cross-request. In reaching this conclusion, we have considered the time devoted to the issue (as represented by claimant's cross-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 claimant's efforts on review regarding the attorney fee issue.

ORDER

The Referee's order dated March 15, 1993 is reversed in part and affirmed in part. For claimant's counsel's pre-hearing efforts in obtaining the withdrawal of Safeco's compensability denial, claimant's attorney is awarded a $1,500 fee, payable by Safeco. The remainder of the Referee's order is affirmed. For services on Board review concerning Fireman's cross-request, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by Fireman's Fund Insurance Companies.

In the Matter of the Compensation of
BRUCE G. HARP, Claimant
WCB Case No. MS-93007
ORDER ON REVIEW OF DIRECTOR'S ORDER (ORS 656.327(1)(b))
Olson & Rowell, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Claimant requests review of the Director's Final Order finding no bona fide medical services dispute under ORS 656.327(1)(b). On review, the issue is jurisdiction. We set aside the order.

Claimant has an accepted 1986 head injury claim. After claim closure, claimant continued to experience headaches. By Order on Review, the Board held that claimant's headaches were compensable.

Claimant's treating physician, Dr. Narus, recommended that claimant undergo evaluation at the Oregon Pain Center for his chronic headache condition. An Opinion and Order found the proposed pain center treatment was causally related to claimant's compensable headache condition. However, based on the Board's orders in Stanley Meyers, 43 Van Natta 2643 (1991), and Kevin S. Keller, 44 Van Natta 2643 (1991), the Referee concluded that the Hearings Division lacked jurisdiction to consider the reasonableness and necessity of the proposed medical services.

The insurer then denied authorization for treatment at the pain center on the basis that it constituted palliative care and that claimant was ineligible for such treatment because he had removed himself from the work force. Claimant requested review by the Director pursuant to ORS 656.327(1). The Director issued an order agreeing with the insurer that the proposed treatment qualified as palliative care and, therefore, review under ORS 656.327(1)(a) was not applicable. Consequently, the Director concluded that no bona fide medical services dispute existed. Claimant requested Board review. See ORS 656.327(1)(b).

ORS 656.327(1) provides for review by the director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services[.]" In Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment. Moreover, the court determined that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 466-67.

Although noting OAR 436-10-046(1), which provides that the Director's review of medical services under ORS 656.327(1) includes treatment that the worker "has received, is receiving, or has been proposed to receive," the court stated that it was not asked to consider its validity. Id. at 467 n.1. The insurer argues that, notwithstanding the holding in Jefferson, the Board is required to apply the rule because it does not conflict with the statute.

We find no merit to the insurer's assertion. Because OAR 436-10-046(1) includes proposed medical services as subject to Director review under ORS 656.327(1), it is contrary to the court's construction of the statute. Thus, we give it no effect. See e.g. Alan G. Herron, 43 Van Natta 1097, 1103 (1991), rev'd on other grounds SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992).

Furthermore, the dispute here pertains to the propriety of proposed pain center treatment. Based on Jefferson v. Sam's Cafe, supra, we find that the procedure contained in ORS 656.327(1) is not applicable and, therefore, claimant was not entitled to Director review under the statute. Consequently, because the Director lacked jurisdiction to address claimant's request for review of the proposed pain center treatment, we set aside the order finding no bona medical services dispute. See ORS 656.327(1)(b); Jefferson v. Sam's Cafe, supra.

ORDER

The Director's order dated August 13, 1993 is set aside.

In the Matter of the Compensation of
SHANNON K. HARTSHORN, Claimant
WCB Case No. 92-14410
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of those portions of Referee Podnar's order which: (1) directed it to pay temporary disability compensation granted by a Notice of Closure; and (2) assessed a penalty and related attorney fee for its allegedly unreasonable delay in paying claimant's temporary disability compensation. On review, the issues are stay of compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings" with exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF was not entitled to stay compensation as awarded by the June 18, 1992 Notice of Closure. Therefore, the Referee found that SAIF's nonpayment of temporary disability benefits amounted to an unreasonable delay in payment of compensation under ORS 656.262(10) and assessed a penalty on that basis. We disagree.

Under ORS 656.313(1)(a), a carrier is entitled to stay payment of a worker's temporary and/or permanent disability award pending its appeal of an earlier Referee's compensation decision. See Diamond Fruit Growers v. Goss, 120 Or App 390 (1993); Felipe A. Rocha, 45 Van Natta 47 (1993). In Rocha, we stated that the phrase in ORS 656.313(1)(a)(A), "benefits 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 processing. We concluded that a carrier was entitled to stay the payment of "pre-litigation order" 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 compensability decision, regardless of whether a Determination Order had awarded "pre-litigation" temporary disability. Id. at 50.

In this case, the June 18, 1992 Notice of Closure (NOC) awarded claimant temporary total disability from December 5, 1989 through January 2, 1990 and from August 30, 1990 through November 30, 1990. The NOC also awarded temporary partial disability from December 1, 1990 through September 24, 1991 and from December 14, 1991 through January 8, 1992. These time periods preceded the prior referee's June 1, 1992 Opinion and Order that awarded temporary total disability benefits for the period from February 8, 1991 through March 25, 1992.

We find that the holding in Rocha is applicable to this case. When SAIF requested review of the prior referee's order awarding temporary total disability benefits for the period from February 8, 1991 through March 25, 1992, it was entitled to stay payment of "the compensation appealed" to which claimant would be entitled if the order had become final. To do otherwise would nullify SAIF's entitlement to stay compensation pursuant to ORS 656.313(1)(a)(A) and Rocha, supra. Furthermore, we conclude that a contrary holding would effectively penalize SAIF for its closure of the claim as required by ORS 656.268(4)(a). Finally, we do not find the fact that Rocha referred to a pending "compensability" appeal distinguishes this case from Rocha. The ultimate issue here, as in Rocha, is a carrier's right to stay compensation pending appeal.

However, we emphasize that a carrier's appeal of a prior order awarding compensation stays payment of only those benefits that are subject to the appeal. Here, only a portion of the benefits awarded by the NOC were subject to SAIF's appeal of the prior referee's order. Hence, SAIF's appeal did not stay payment of all benefits awarded by the NOC; those benefits that were not subject to SAIF's appeal were not stayed.

Inasmuch as SAIF requested Board review of the prior referee's order and because the NOC temporary disability award was not for a period accruing from the date of that Referee's order, we conclude that SAIF properly stayed payment of the temporary disability award provided by the June 18, 1992 NOC, pending its appeal.

Accordingly, we reverse that portion of the Referee's order which directed SAIF to pay temporary partial disability from February 8, 1991 through September 24, 1991 and from December 14, 1991 through January 8, 1992. Since we have found that SAIF was statutorily entitled to stay payment of the temporary disability award, it follows that its conduct was not unreasonable. Consequently, we also reverse the Referee's penalty assessment and attorney fee award.

ORDER

The Referee's order dated March 25, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that directed the SAIF Corporation to pay temporary disability compensation from February 8, 1991 through September 24, 1991 and from December 14, 1991 through January 8, 1992, as granted by a Notice of Closure, is reversed. Those portions of the order that assessed a penalty and awarded an approved fee out of additional temporary disability are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHIRLEY A. McCOY, Claimant
WCB Case No. 92-15184
ORDER ON REVIEW
Crispin & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Lipton's order that granted the insurer's motion to dismiss claimant's request for hearing from the insurer's denial of her occupational disease claim and aggravation claim for a psychological condition. On review, the issues are the propriety of the Referee's dismissal and, if not proper, compensability and aggravation. We reverse the Referee's order of dismissal and uphold the insurer's denial.

FINDINGS OF FACT

Claimant has worked for the employer since 1981 operating machine saws. She has a compensable 1986 mental disorder claim based on work-related stress.

On July 7, 1992, claimant became upset after her supervisor, Larry Doan, relayed instructions to claimant through a co-worker. Claimant became more upset after Doan rejected claimant's attempt to speak with Doan and her request to take vacation for the rest of the day. Claimant then left work. Claimant received a verbal warning.

On July 11, 1992, claimant found on her saw a portion of a carton with an arrow pointing to the pre-printed words "12 tampons" and a handwritten message stating "Will take all 12 for [claimant]." Claimant gave the material to Doan, who attempted to discover the perpetrator. Eventually, a co-worker confessed, stating that it was intended as a joke. The co-worker received a written warning.

On August 13, 1992, another co-worker approached claimant with the same portion of carton and stated, "Should I circle this?" After claimant reported the incident, the co-worker also received a written warning.

On October 27, 1992, Doan took a phone call for claimant concerning company business. The caller left a message for claimant. About an hour after the phone call, Doan passed the message to claimant. Claimant became upset because Doan did not let her take the phone call; claimant and Doan then got into a verbal altercation. Marcus Pollard, section supervisor, attempted to speak with claimant without success. Claimant received a written warning.

Claimant subsequently sought treatment from Dr. Swartzel for job stress; Dr. Swartzel referred claimant to Dr. Browning, occupational health specialist. Claimant also received treatment from Dr. Ruud, psychiatrist, and Dr. Watkins, psychiatrist.

The insurer denied claimant's occupational disease and aggravation claims for a mental disorder. At hearing, after claimant presented her case-in-chief, the Referee granted the insurer's motion to dismiss on the basis that claimant had offered no medical evidence proving causation.

CONCLUSIONS OF LAW AND OPINION

Propriety of Dismissal

Claimant first objects to the Referee's ruling dismissing her request for hearing. We agree that the Referee improperly granted the motion to dismiss.

The only basis for dismissing a timely filed request for hearing is upon a finding that "the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in unjustified delay in the hearing of more than 60 days." OAR 438-06-071. There was no evidence or contention that claimant unjustifiably delayed the hearing. Furthermore, claimant did not abandon the request for hearing; rather, both she and her attorney were present at the hearing and went forward with litigating the case. Consequently, there was no basis for granting the motion to dismiss.

Having found that the Referee improperly dismissed the request for hearing, and finding that the record was sufficiently developed for purposes of review, we proceed to the merits.

Aggravation and Compensability

Claimant contends that her current psychological condition is a compensable aggravation of her 1986 mental disorder claim and/or a compensable mental disorder condition. We disagree.

Claimant initially sought treatment from Dr. Swartzel. Although diagnosing her condition as "job stress" and "depression," Dr. Swartzel did not provide an opinion regarding causation. (Exs. 14, 15). Dr. Browning diagnosed "adjustment disorder with mixed emotional features." (Exs. 17, 18, 20E). Dr. Browning also did not indicate the cause of claimant's mental condition.

Claimant underwent a medical examination with Dr. Turco, psychiatrist. Although finding that claimant had an "occupational problem," Dr. Turco reported that she had no "diagnosable psychological condition associated with her work[.]" (Ex. 19-4). A second medical examination with Dr. Lammers, psychologist, also found no "diagnosable psychological condition or disorder that is the direct result of her job or work activities." (Ex. 21-7). Drs. Swartzel and Browning concurred with Dr. Lammers' report. (Exs. 26, 27).

Dr. Watkins diagnosed "major depression, recurrent." (Ex. 22). In discussing causation, Dr. Watkins reported that claimant's condition was "chronic" and "recurring" "of a biologic origin, rather than psychological in response to stressors around her." (Ex. 23-2). Dr. Watkins further stated that the condition did not "arise[] from conditions at her work, but are more of an ongoing difficulty that she has [sic] frequently is experienced by the person as something physical and external and imposed upon them somehow[.]" (Id. at 2-3).

Finally, Dr. Ruud, who also examined claimant in 1987, diagnosed adjustment disorder with mixed emotional features. (Ex. 30-4). Dr. Ruud reported that, with regard to the legitimacy of the claim, his role was "neutral." (Ex. 30-3). Dr. Ruud also indicated that claimant's "current symptoms seem related to the perceived job stresses" but that it was "unclear if the stresses at work are true." (Id. at 3-4). Dr. Ruud also noted that "personality traits *** may be aggravating her situation." (Id. at 4).

The only opinion that demonstrated a causal relationship between claimant's work activities and her psychological condition was that rendered by Dr. Ruud. However, Dr. Ruud indicated only that claimant's symptoms "seem related" to job stress, noting that personality traits also could be a factor and that there was some question whether the job stresses were "true." Under such circumstances, whether analyzed under a "material" or "major" contributing cause standard, we find that the opinion is not sufficient to prove a compensable aggravation claim or occupational disease claim. See ORS 656.273(1), 656.802(2).

ORDER

The Referee's order dated February 16, 1993 is reversed. Claimant's request for hearing is reinstated. The insurer's denial is upheld.

January 5, 1994 Cite as 46 Van Natta 21 (1994)

In the Matter of the Compensation of
TROY SHOOPMAN, Claimant
WCB Case No. 92-09702
ORDER ON REVIEW (REMANDING)
Richard F. McGinty, Claimant Attorney
Lane, Powell, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Spangler's order that: (1) declined to award additional temporary disability; 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 remand.

FINDINGS OF FACT

With the exception of the "Ultimate Findings of Fact," we adopt the "Findings of Fact" contained in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Following his compensable injury, claimant returned to work for his employer performing modified duties. His wages were not affected by the change in his work assignment. Thereafter, claimant was terminated from his employment for allegedly violating his employer's "drug and alcohol" policy; i.e., failing to submit to a test within 24 hours of a work-related accident to rule out the involvement of alcohol or drugs as a contributing factor to any work-related medical condition. When the self-insured employer did not pay temporary disability after claimant's discharge, claimant requested a hearing.

The Referee expressed some doubt as to whether claimant's termination was justified in that the employer's policy could be construed as requiring the employer to schedule the appropriate drug and alcohol test. Nevertheless, reasoning that the propriety of claimant's discharge was an issue for another forum (ORS 659.410), the Referee concluded that claimant was not entitled to temporary disability because he had not established that his termination was attributable to any inability to work due to his compensable injury.

The Referee's conclusion was consistent with the court's holding in Stone v. Whittier Wood Products, 116 Or App 427 (1992). However, the court has recently vacated and reconsidered that opinion. 124 Or App 117 (1993). In Stone, the court reversed a Board order which had found that the claimant was not entitled to temporary disability because she had been discharged from her modified job for reasons unrelated to her compensable injury (absenteeism and violation of a drug/alcohol policy). Computing the claimant's temporary partial disability (TPD) under OAR 436-60-030(2) at zero, the carrier in Stone did not reinstate temporary disability benefits after her discharge.

The Stone court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages.[1] In doing so, the court determined that the Board's application of OAR 436-60-030(2) improperly restricted the claimant's TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work).

In reaching its conclusion, the Stone court reasoned that an injured worker's post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Here, other than evidence confirming that claimant's at-injury wage was not affected by his return to work in a light-duty position, the record is devoid of either documentary or testimonial evidence regarding claimant's "earning power at any kind of work." In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work.

Furthermore, considering that this record was developed prior to the Stone court's interpretation of ORS 656.212 and its attention to diminished earning power at any kind of work in calculating TPD, we find that there is a compelling reason to remand for the submission of additional evidence.[2] See ORS 656.295(5); Betty S. Tee, 45 Van Natta 289 (1993) (Remand warranted to further develop record to include evidence regarding whether part-time employment opportunities constituted employments for "profitable remuneration" for purposes of determining entitlement to permanent total disability benefits under recent Supreme Court holding).

Accordingly, we vacate the Referee's order dated October 16, 1992. This matter is remanded to Referee Spangler for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] A medical report from the Western Medical Consultants contains a brief reference to claimant's prior employments as a dock worker and gas pumper. However, there is no mention of claimant's wages in those employments nor is there any discussion of claimant's earning power at any kind of work.

[2] Although the court's holding in Stone would appear to require a re-opening of this record for further development of the evidence in order to determine claimant's "earning power at any kind of work," we note that the court has not offered any guidance regarding how such a determination should be made. In light of such circumstances, and in the absence of a post-Stone Director's rule on TPD, we offer the following recommendation to the parties and the Referee on remand. When attempting to calculate claimant's TPD, evidence presented by the parties should include (but is not limited to) a review of claimant's employment history (including past/current wages).

In the Matter of the Compensation of
DIANA L. BRETT, Claimant
WCB Case No. 92-12471
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Bethlahmy's order that dismissed claimant's hearing request concerning an Order on Reconsideration. Noting that the reconsideration order had issued while the SAIF Corporation was responsible for processing the claim, the Referee reasoned that claimant's hearing request was no longer ripe because Liberty Northwest Insurance Corporation (not SAIF) had recently been found responsible for the claim by a Board order. Inasmuch as responsibility for the claim has not been finally resolved (i.e., the Board order finding Liberty Northwest responsible was appealed and remains pending before the court), claimant contends that the Referee should have either deferred this matter or joined Liberty Northwest as a party to this proceeding.

We affirm the Referee's decision based on the following reasoning.

Claimant requested a hearing from a September 17, 1992 Order on Reconsideration which awarded no permanent disability. That order had issued as a result of SAIF's claim processing. However, while the hearing request was pending, the Board found Liberty Northwest responsible for processing of the claim. Liberty has petitioned for judicial review of the Board's responsibility determination.

Over claimant's objection, the Referee granted a motion by SAIF to dismiss it as a party from the hearing. In addition to granting SAIF's motion to dismiss, the Referee set up a new WCB case number for claimant's request for hearing concerning the Order on Reconsideration which included Liberty as a party in interest. This new hearing has been convened and resulted in a July 16, 1993 order by Referee Mills. Pursuant to that order, the Order on Reconsideration has been affirmed. Referee Mills' order has not been appealed.

On review, claimant continues to object to SAIF's dismissal and contends that this case should have either been deferred pending the ultimate outcome of the responsibility litigation or Liberty should have been joined as a party to this proceeding. Although we disagree with some of the preliminary procedures taken in this case, subsequent events have made it unnecessary to alter the Referee's decision.

Upon issuance of the Board's order finding Liberty responsible for claimant's low back condition, it became Liberty's duty to process the claim even though SAIF had been the insurer which had processed the claim to closure which resulted in the Reconsideration Order. In other words, as a result of the Board's order assigning responsibility to Liberty, SAIF was no longer primarily responsible for litigation of any claim processing issue (including the extent of claimant's permanent disability).

Although we agree that SAIF was not required to participate in the extent hearing (should it choose not to attend), we disagree with the Referee's decision to dismiss claimant's hearing request concerning SAIF by means of a final appealable order. Instead, the Referee could have excused SAIF from formal participation in the proceeding and Liberty Northwest could have been joined in the proceeding. These actions could have been taken by means of an "interim order," which would not only have satisfied each parties' primary concern, but would have achieved the Board's policy and preference of avoiding piecemeal review of multiple issues arising from the same claim. See Joseph C. Hackler, 45 Van Natta 1450 (1993). Addressing such pre-hearing matters by way of an interim order not only avoids the potential for "piecemeal review" of "preliminary" orders, but it allows the parties to be notified of the Referee's pre-hearing rulings while permitting a carrier's formal dismissal as a party to be incorporated into the Referee's eventual final appealable order. Id.

In light of the aforementioned policy and rationale, we conclude that an interim order would have been the appropriate method for granting SAIF's dismissal and for joining Liberty as a party to the proceeding. Such an approach would have accomplished the parties' primary concerns (SAIF's concern being permission not to attend the "extent" hearing; claimant's concern being not dismissing SAIF as a party to the hearing) while avoiding the potential for piecemeal litigation. Thus, to rectify such a

situation we would normally remand the case for consolidation with the "Liberty Northwest" hearing. However, in this particular situation as a result of subsequent events, remand is unnecessary.

While the present case was pending review by the Board, a hearing was held before Referee Mills concerning the extent of claimant's unscheduled permanent disability. Liberty and claimant were the parties to this hearing. Finding that claimant had not established entitlement to an award of unscheduled permanent disability, Referee Mills affirmed the September 17, 1992 Order on Reconsideration. Referee Mills' July 16, 1993 order has not been appealed and has become final.

Thus, regardless of which carrier is ultimately found responsible for claimant's low back condition, this claim has now been properly processed to closure and litigation concerning the extent of permanent disability is final by operation of law. Accordingly, remand would achieve no purpose.

ORDER

The Referee's order dated March 26, 1993 is affirmed.

In the Matter of the Compensation of
GUSTAVO CANTU-RODRIGUEZ, Claimant
WCB Case No. 92-15963
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Claimant requests reconsideration and abatement of our December 8, 1993 Order on Review wherein we cited Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991) and held that claimant was not entitled to an attorney fee under ORS 656.382(1) because there was no compensation due. Contrary to claimant's assertion in the request for reconsideration, Boehr does not eliminate the need for a resistance to compensation before a fee can be awarded under ORS 656.382(1).

We interpret the several decisions on this issue from the Court of Appeals to require: (1) a compensable claim; (2) unreasonable conduct; and (3) which then results in the resistance to compensation. Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991); Boehr v. Mid-Willamette Valley Food, supra; Martinez v. Dallas Nursing Home, 114 Or App 253 (1992); Oliver v. Norstar, Inc., 116 Or App 333 (1992); SAIF v. Condon, 119 Or App 194 (1993).

We recognize an apparent conflict between Randall v. Liberty Northwest Ins. Corp., supra (fee awarded under ORS 656.382(1) rather than ORS 656.262(10) in the absence of "amounts then due") and Aetna Casualty Co. v. Jackson, supra (fee not proper under ORS 656.382(1) since the compensation had been paid). See SAIF v. Condon, supra, 119 Or App at 196.

In light of Jackson and Condon (and the requirement that compensation be due before a fee is available under ORS 656.382(1)) and in light of Martinez, supra, and Oliver, supra (fee not available under 656.382(1) if the conduct is subject to a penalty/fee under ORS 656.262(10) (which also requires an "amount then due")), it may be that ORS 656.382(1) has been effectively (judicially) removed from Chapter 656. The Court of Appeals has not yet explained what "type" of conduct would give rise to an assessment of a fee under ORS 656.382(1). See Oliver v. Norstar, Inc., supra, 116 Or App at 336.

In the instant case, the underlying claim is compensable and we have found SAIF's conduct to be unreasonable. Unless, however, this conduct (premature determination of vocational assistance ineligibility) can be deemed to constitute the resistance of compensation, there is no basis to award an attorney fee under ORS 656.382(1).

Consequently, we withdraw our December 8, 1993 order. On reconsideration, as supplemented herein, we republish our December 8, 1993 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
DEBORAH K. JENNINGS, Claimant
WCB Case No. 92-11751
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of those portions of Referee Nielsen's order that: (1) set aside its denial of claimant's occupational disease claim for a fibromyalgia condition; and (2) assessed a penalty based on amounts expected to become due. Claimant cross-requests review, asserting entitlement to an attorney fee, if the penalty is reversed. On review, the issues are scope of acceptance or compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant's work activities, including computer data entry, were the major contributing cause of her fibromyalgia condition.

CONCLUSIONS OF LAW AND OPINION

Scope of acceptance/compensability

The Referee found that the employer accepted claimant's fibromyalgia condition when it accepted her March 8, 1991 claim for a cervical strain. Alternatively, the Referee concluded that claimant's fibromyalgia is compensable, because it was directly caused by the compensable chronic neck strain.

The employer argues that it accepted only a cervical strain, not the later-diagnosed fibromyalgia condition. Claimant contends that her condition has not changed and she has suffered from fibromyalgia all along.

We note at the outset that the record contains no specific or official notice of acceptance. See Johnson v. Spectra Physics, 303 Or 49 (1987). However, we need not determine the scope of the employer's acceptance, because we agree with the Referee that the claim is compensable (regardless of the diagnosis),[1] based on the following reasoning.

Claimant's neck and upper back problems were gradual in onset and associated with her repetitive work activities for the employer. Consequently, if the claim is compensable, it is properly characterized as an "occupational disease." See ORS 656.802; Valtinson v. SAIF, 56 Or App 184, 187 (1982). Accordingly, to carry her burden, claimant must establish that her work exposure was the major contributing cause of her neck and upper back fibromyalgia condition or its worsening. ORS 656.802(1)(c).

We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983).

Here, the medical evidence concerning causation is provided by Dr. Lockfeld, neurologist, and Dr. Baker, orthopedist. Lockfeld, who treated claimant for her neck and upper back complaints from March 22, 1991 until May 1992, opined that claimant "may have an underlying predisposition to fibromyalgia which can be precipitated by her work activities." (Ex. 24-1). Although he was unable to

[1] Over the course of this claim, claimant's problems have been variously diagnosed as a neck strain, a bulging cervical disc, fibromyalgia and myofascial pain syndrome.

determine the exact relative contributions of claimant's "natural predisposition" and her work, Lockfeld concluded, "Certainly, both contribute." (Ex. 7-8). Noting that claimant was "spending increased and prolonged amounts of time at a computer terminal as part of her employment," Lockfeld opined that claimant's work activity contributed to her fibromyalgia condition. (Ex. 24-1).

Dr. Baker opined that claimant's "fibromyalgia condition may well be accentuated by her work activities." (Ex. 23-4). However, he also stated that the underlying cause of the condition is idiopathic and not work related. (Id.) In our view, Baker's opinion is not particularly well-reasoned. Moreover, considering Lockfeld's accurate history, his advantage as claimant's treating physician, and his well-reasoned opinion, we find no persuasive reason to discount Lockfeld's conclusion that claimant's work activities contributed to her fibromyalgia. See Weiland v. SAIF, supra. Further considering that claimant's predisposition to fibromyalgia does not weigh against her claim and the fact that she leads a sedentary life off-work, we conclude, based on Lockfeld's opinion, that claimant has carried her burden of proof. See Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991). Consequently, the claim is compensable.

Penalty/attorney fees

The Referee assessed a penalty of 25 percent of amounts "which may become due" in relation to Dr. Lockfeld's recommendation for pain center treatment. In this regard, the Referee determined that the employer's failure to either pay for the treatment or refer the matter to the Director constituted unreasonable resistance to the payment of compensation under ORS 656.262(10). We reverse the penalty assessment and award an attorney fee instead, based on the following reasoning.

Dr. Lockfeld filed a claim for pain center treatment on claimant's behalf. The employer received notice of this claim by March 27, 1992. (See Ex. 7-7; see also Exs. 7-5, 7-8, 21). The employer did not respond to the claim until August 10, 1992, more than 90 days after the claim was filed. See ORS 656.262(6)&(10). Under these circumstances, we agree with the Referee that the failure to timely process the claim constituted unreasonable resistance to the payment of compensation.

However, because the record reveals no amounts owing under the compensable claim, there are no "amounts then due" which would otherwise support a penalty under ORS 656.262(10). See Richard J. Stevenson, 43 Van Natta 1883 (1991). Consequently, the penalty assessment must be reversed.

ORS 656.382(1) warrants an attorney fee when an employer engages in conduct which constitutes unreasonable resistance to the payment of compensation, even though there are no amounts due upon which to base a penalty. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992); Richard J. Stevenson, supra. Here, because the employer's failure to process the claim for pain center treatment constituted unreasonable resistance to the payment of compensation, an attorney fee is awarded on this basis. See ORS 656.382(1). Having considered the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that a reasonable fee for claimant's counsel's services concerning the failure to timely process the medical services claim is $300, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

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 statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 19, 1993 is reversed in part and affirmed in part. That portion of the order that awarded a penalty is reversed. In lieu of the penalty, claimant's counsel is awarded an assessed attorney fee of $300, to be paid by the employer. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded a $900 attorney fee, payable by the employer.

In the Matter of the Compensation of
CATHERINE D. TOWNSEND, Claimant
WCB Case Nos. 93-03755, 92-13371, 92-11845 & 92-07303
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Luvaas, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Breathouwer, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Garaventa's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld the denials of Gates Mcdonald and AIAC of the same claim. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

After the 1986 Disputed Claim Settlement between claimant and Gates McDonald, claimant's next right shoulder complaints were reported in January 1990 to Dr. Cutler. AIAC was providing coverage for claimant's employer at this time. However, claimant neither received medical treatment for her complaints nor did she miss time from work.

Claimant first received medical treatment for her right shoulder condition on December 5, 1991, when she was examined by Dr. Reeves. Liberty (who came on the risk in August 1991) was providing coverage for claimant's employer at this time.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's "Conclusions and Opinion" on the compensability issue, with the following modification.

We apply ORS 656.802, rather than ORS 656.005(7)(a)(B), in evaluating compensability because this claim is properly analyzed as an occupational disease. See Lizbeth Meeker, 44 Van Natta 2069, 2071 (1992).

Responsibility

We adopt the Referee's "Conclusions and Opinion" on the responsibility issue, with the following modification.

The Referee correctly identified the date of claimant's right shoulder disability as the triggering date for assigning responsibility under the last injurious exposure rule. Further, because claimant's 1986 right shoulder disability is not compensable by virtue of claimant's agreement (DCS) with Gates McDonald, the Referee properly determined that responsibility is not initially assigned with Gates McDonald (the carrier on the risk at the time of the 1986 disability). See Dewain J. Mecham, 45 Van Natta 1200 (1993).

Finding that claimant's "disability date" was January 1990, the Referee initially assigned responsibility for claimant's right shoulder condition to AIAC. Determining that claimant's subsequent work activities were the major contributing cause of a worsening of her condition, the Referee held that responsibility shifted to Liberty. See Fred A. Nutter, 44 Van Natta 854 (1992).

Although claimant complained of right shoulder symptoms in January 1990 when she sought treatment for bilateral hand and arm complaints, she did not receive medical treatment for her right shoulder condition until December 1991. Consequently, responsibility is initially assigned to Liberty, who was on the risk at time claimant first received treatment for her right shoulder compensable condition. See Timm v. Maley, 125 Or App 396 (1993).

In order to shift responsibility to an earlier carrier, Liberty must establish that prior work conditions were the sole cause of claimant's right shoulder disease or that it was impossible for work conditions during the last period of employment to have caused the disease. FMC Corporation v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). Because Liberty has made no such showing, we agree with the Referee's ultimate conclusion that Liberty is responsible for claimant's right shoulder condition.

Alternatively, even if January 1990 was treated as claimant's disability date, we agree with the Referee's conclusion that responsibility for claimant's right shoulder condition would shift to Liberty. Our review of the medical evidence establishes that claimant's "post-January 1990" work activities independently contributed to the cause or worsening of her right shoulder condition. See Timm v. Maley, supra.[1] Consequently, although initial initial responsibility would be assigned to AIAC (the carrier on the risk in January 1990), responsibility would shift to Liberty (the subsequent insurer).

Attorney fees

Inasmuch as claimant's compensation was not disallowed or reduced on review, she is entitled to an attorney fee for her counsel's services. 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 attorney's services on review is $750, to be paid by Liberty. 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 27, 1993 is affirmed. For services on Board review, claimant's attorney is awarded a $750 attorney fee, payable by Liberty.

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[1] In reaching this conclusion, we find the opinion offered by Dr. Reeves, claimant's attending osteopathic physician, to be particularly persuasive. Reeves attributed claimant's right shoulder problems to her work activities from November 1986 through November 1992. (Ex. 78). This opinion was echoed by Dr. Watrous, orthopedic surgeon, who concluded that claimant's right shoulder condition was the direct result of her general work activities from 1986 to November 1992. (Ex. 79).

In the Matter of the Compensation of
EDWARD C. STEELE, Claimant
WCB Case No. 92-11385
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Michael Johnson's order which: (1) declined to recalculate claimant's wage rate; and (2) declined to assess a penalty based on an alleged delay in surgery. On review, the issues are rate of temporary disability and penalties.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated February 17, 1993 is affirmed.

Board Member Gunn dissenting.

Claimant is a long-haul truck driver, who is paid 15¢ per mile and a per diem of 4¢ per mile. The majority holds that the per diem was intended to be reimbursement for out-of-pocket expenses while claimant was on the road, and thus is not wages for purposes of calculating his temporary disability rate. Because I would conclude that the 4¢ per diem is part of his wage, I dissent.

"Wages" are defined as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer***." ORS 656.005(27).

Temporary disability compensation is calculated as a percentage of wages. ORS 656.210. The purpose of temporary disability is to replace lost wages/income. Cutright v. Weyerhaeuser, 299 Or 290 (1985); Crumley v. Combustion Engineering, 92 Or App 439 (1988). Claimant lost wages/income as a result of his compensable injury. Because he did not receive the per diem when he was not working as a result of his injury, he lost that portion of his income. Therefore, his temporary disability, and thus, his wage rate calculation should include the 4¢ per diem.

Secondly, claimant is a traveling employee. See Pacific Power & Light v. Jacobsen, 121 Or App 260 (1993). As such, he may incur expenses on the road for such necessities as food and lodging. Under the contract of hire, claimant would be responsible for these expenses, but received money for these expenses in the form of a per diem. Although labeled as a per diem, that money does not lose its identity as part of claimant's wages paid for services rendered. The expenses were incurred incidental to claimant performing his job.

Unlike a reimbursable expense, claimant was not required to account to the employer for moneys spent for such things as food and lodging while on the road. Also, unlike an expense, claimant received the per diem regardless if he incurred any out-of-pocket expenses while out on the road.

This per diem is similar to a worker who works the night shift and receives a "wage differential" for the inconvenience of working at night. In this case, the per diem is to compensate claimant for the inconveniences caused by traveling away from his employer's premises.

Finally, the per diem would be considered taxable income under the IRS code. Although the employer took no deductions out of claimant's per diem check, the IRS surely would.

For the above reasons, I would find that the 4¢ per diem should be included as wages for purposes of calculating claimant's temporary disability rate. Therefore, I dissent.

In the Matter of the Compensation of
DAN A. DAVIS, Claimant
WCB Case No. 93-00961
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Gunn, Westerband and Haynes.

The insurer requests review of Referee Howell's order that set aside its partial denial of claimant's L5-S1 disc herniation. On review, the issue is compensability.

The Board affirms and adopts the order of the Referee.

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 assessed attorney fee for claimant's counsel'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 case (as represented by claimant's respondent's brief and claimant's counsel's statement of service), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 10, 1993, as reconsidered May 21, 1993, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the insurer.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that claimant has met his burden of proving that his industrial accident was a material contributing cause of his L5-S1 disc herniation and the resultant disability and need for medical services. ORS 656.005(7)(a). Because I believe that there has been an utter failure of proof, I dissent.

It is well-settled that we accord little, if any, weight to medical opinions that are based on inaccurate histories. See, e.g., Somers v. SAIF, 77 Or App 259 (1986); Luella M. Best, 45 Van Natta 1638 (1993). The majority ignores that rule here.

Claimant relies on the opinions of Drs. Byfield, Gallo and Andresen. The Referee, and the majority, correctly discount the opinions of Drs. Byfield and Gallo because they are based on substantially inaccurate histories regarding the mechanism of claimant's injury. However, both the Referee and the majority go astray with respect to Dr. Andresen's opinion.

Dr. Andresen's reports do not refer to the precise mechanism of claimant's injury. However, the opinion that is given the most weight is Dr. Andresen's review of an IME report by Drs. Bobker and Bellville, (Ex. 58B), which report includes a history of claimant being hit by a 20 to 25 pound, 6-feet long piece of 2-by-6 that threw claimant several feet across the room. (Ex. 57-1.) By implication, Dr. Andresen's review of that report also relies on that history. Because the evidence reveals that that history is inaccurate, (e.g., Tr. 32, 37-38, 43), Dr. Andresen's review opinion is entitled to no weight.

The Referee, and now the Board, seek to avoid this conclusion by reasoning that, because Dr. Andresen relied on the proximity between claimant's injury and his onset of back symptoms, and not the mechanism of injury, Dr. Andresen's opinion is sufficient to meet claimant's burden of proof. Opinion and Order at 6. That reasoning is flawed. If one culls out the mechanism of injury from the analysis, all that is left is a temporal relationship between claimant's injury and his current back condition. Because such a relationship is insufficient to satisfy claimant's burden, ORS 656.266, Robin G. Rothe, 45 Van Natta 369 (1993), claimant's current back condition is not compensable.

For the foregoing reasons, I respectfully dissent.

In the Matter of the Compensation of
DAVID J. KIESOW, Claimant
WCB Case No. 93-00020
ORDER ON REVIEW
Daniel Spencer, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of Referee Howell's order which upheld the SAIF Corporation's denial of his low back injury claim. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated April 23, 1993 is affirmed.

Board Member Hall dissenting.

The Referee concluded, and the majority agreed, that the opinion of the attending physician, Dr. Tuft, was unpersuasive because he did not quantify or address the relative contribution of claimant's preexisting back condition. Therefore, based on the opinion of Dr. Sulkosky, the Board agreed with the Referee that claimant failed to prove his on-the-job injury was the major contributing cause of his disability or need for treatment on and after September 28, 1992. I disagree.

Here, no one disputes that there was a September 28, 1992 work injury. Further, the fact that claimant experienced increased low back symptoms with the September 1992 injury is also not disputed. The only issue is whether the work injury which combined with his preexisting back condition is the major contributing cause of claimant's acute low back strain.

Dr. Tuft specifically considered whether claimant's current condition was an aggravation of his preexisting injury. (Ex. 22-1). Dr. Tuft also considered whether claimant's resultant acute low back strain was produced by a combination of his preexisting back condition and work injury. (Ex. 24; 25). Dr. Tuft opined that such a finding was "plausible." (Ex. 22). However, after considering the relative contribution of the other causal factors identified, Dr. Tuft opined that "the work injury was of sufficient magnitude to produce an acute back strain." (Ex. 25-1). Dr. Tuft concluded that "the work injury was the major contributing cause of the resultant condition, that is the acute low back strain." (Id.) (Emphasis in original).

Accordingly, I find that Dr. Tuft did, in fact, address the relative contribution of claimant's preexisting back condition. Moreover, Dr. Tuft's opinion supports a finding that the work injury is the major cause of claimant's September 1992 acute low back strain.

The present case is similar to Eileen M. Winfree, 45 Van Natta 1805 (1993). In Eileen M. Winfree, we concluded that a new injury was proven where the doctor's opinion was consistent with the claimant's testimony, the claimant reported new and more severe symptoms following a work injury, and the claimant's testimony was supported by the record. That is the case here.

Based on Dr. Tuft's opinion, and consistent with Winfree, supra, I would find that claimant proved by a preponderance of the evidence that the work injury is the major contributing cause of his September 1992 acute low back strain. Therefore, I dissent.

In the Matter of the Compensation of
RAY L. BENNETT, Claimant
WCB Case No. 92-02102
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Referee Baker's order that: (1) declined to set aside the September 6, 1991 Determination Order as prematurely issued; and (2) awarded a $600 insurer-paid attorney fee under ORS 656.386(1). On review, the issues are premature claim closure 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

Premature Claim Closure

We affirm and adopt the Referee's order on the premature claim closure issue with the following supplementation.

Claimant suffered a compensable injury on May 7, 1991 that was accepted as a disabling injury claim for cervical and lower thoracic strains by Notice of Claim Acceptance of July 31, 1991. However, there were references in the medical record to a left hip contusion and to a lumbar strain prior to the notice of acceptance being issued. Dr. Talley, claimant's attending physician, declared claimant medically stationary in an August 29, 1991 medical report. Dr. Talley gave several diagnoses, among which were resolved cervical-thoracic strain and resolved lumbar strain. No mention was made of claimant's left hip contusion, nor was there any indication that claimant was experiencing symptoms in the left hip.

Based on Dr. Talley's report, the claim was then closed by Determination Order of September 6, 1991, which did not award any permanent disability. Claimant requested reconsideration, which resulted in a January 29, 1992 Order on Reconsideration that affirmed the Determination Order in all respects. The evaluator only considered the cervical and lower thoracic strains as accepted conditions.

Claimant requested a hearing on May 1, 1992, alleging "de facto" denial of the left hip and lumbar conditions. Shortly before the scheduled hearing on March 18, 1993, the insurer accepted the left hip and lumbar conditions on March 9, 1993.

At hearing, claimant asserted that the September 6, 1991 claim closure was premature since his lumbar and left hip conditions had not been considered in the Determination Order or in the Order on Reconsideration. The Referee declined to set aside the prior closure and, instead, ordered the insurer to process the left hip and lumbar conditions to closure. The Referee also awarded claimant's attorney an assessed fee of $600 for his efforts in securing acceptance of the left hip and lumbar conditions.

Claimant contends that the Referee should have set aside the claim closure because the left hip and lumbar conditions were not considered when the claim was closed. We disagree.

A claimant must be medically stationary from all conditions resulting from the compensable injury before his claim may be closed. Mary J. Mckenzie, 44 Van Natta 2301 (1992). It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhauser Corp., 54 Or App 624 (1981). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

Since claimant's left hip and lumbar conditions were accepted post-closure, the question is whether they were medically stationary when the claim was closed on September 6, 1991. If so, then the September 6, 1991 closure should be affirmed. The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. See Harmon v. SAIF, 54 Or App 121 (1981); Austin v. SAIF, 48 Or App 7 (1980). We find that the left hip and lumbar conditions were medically stationary when the claim was closed. We, accordingly, affirm the claim closure.

Dr. Talley clearly stated that claimant was medically stationary prior to the claim closure. Dr. Talley explicitly referred to claimant's lumbar condition in his report. Although he did not mention claimant's previously diagnosed left hip contusion, we infer from his report that this condition had resolved since claimant was apparently asymptomatic relative to this condition. Further, Dr. Talley did not recommend any additional treatment for the left hip condition. For these reasons, we also conclude that the left hip condition was medically stationary when the claim was closed. Inasmuch as claimant has not carried his burden of proving he was not medically stationary at the time of claim closure, the Referee correctly declined to set aside the claim closure.

Attorney Fee

Claimant also contends that the Referee should have awarded an attorney fee of at least $2,000 for his efforts in securing acceptance of the left hip and lumbar conditions without a hearing. We agree that a larger attorney fee award is justified, although not in the amount that claimant requests.

After considering all the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that a reasonable assessed attorney fee for claimant's services in securing acceptance of the lumbar and left hip conditions is $1,200. In reaching this conclusion, we have considered the time devoted to this issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the benefit secured for claimant and the risk that claimant's counsel might go uncompensated. In particular, we note that the insurer did not accept the left hip and lumbar conditions for almost two years after these conditions were first noted in the medical records. In addition, claimant's counsel's request for hearing resulted in one-half of the total compensable conditions being accepted.

ORDER

The Referee's order dated April 15, 1993 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, claimant's attorney is awarded a fee of $1,200, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN I. JETT, Claimant
WCB Case No. 92-07422
ORDER ON REVIEW
Robert Dolton, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Hoguet's order which set aside its denial of claimant's aggravation claim for his left knee condition. On review, the issue is aggravation.

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

In 1989, claimant compensably injured his left knee while working for an Oregon employer. In 1992, claimant's left knee condition became worse while claimant was working for a Washington employer.

The Referee concluded that claimant had proven a compensable aggravation claim against the Oregon employer. The Referee then applied ORS 656.308, reasoning that the Oregon employer remained responsible unless the Oregon employer could prove that claimant suffered a new injury or occupational disease while working for the Washington employer. Analyzing claimant's "Washington" claim as an occupational disease claim, the Referee held that claimant's Washington employment was not the major contributing cause of his current knee condition. Thus, the Referee determined that the Oregon employer remained responsible for claimant's left knee condition. We agree with the Referee that the Oregon employer remains responsible, but for the following reasons.

To begin, because this "responsibility" dispute pertains to an "out-of-state" employer, we have serious doubts regarding the applicability of ORS 656.308. See ORS 656.005(25); 656.023; see Miville v. SAIF, 76 Or App 603, 607 (1985) (Oregon can apply its own rules consistently between Oregon employers). Furthermore, even if ORS 656.308 were applied, the insurer would be required to prove that the out-of-state incident was the major contributing cause of claimant's left knee condition in February 1992. ORS 656.005(7)(a)(B); see SAIF v. Drews, 318 Or 1 (1993) (ORS 656.005(7)(a)(B) is applicable regardless of whether a "preexisting condition" is compensable or noncompensable).

Here, the Oregon insurer argues that claimant's "out-of-state" claim should be analyzed as an injury. In doing so, the insurer essentially concedes that it cannot meet its burden of proving that the "out-of-state" work incident was the major contributing cause of claimant's left knee condition. (App. Br. at 3). Since the medical evidence does not establish that the "Washington" injury was the major contributing cause of claimant's "resultant disability," we agree with the Referee that the Oregon employer remains responsible for claimant's left knee condition.

Because the "out-of-state" employer would not appear to be subject to Oregon laws, the insurer's aggravation denial is more properly interpreted as a contention that the major contributing cause of claimant's alleged worsening was an injury not occurring within the course and scope of employment. See ORS 656.273(1). Therefore, in order to prevail on its aggravation denial, the Oregon employer/insurer must prove that the major contributing cause of claimant's left knee condition was the February 1992 "Washington" work incident. See Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992) (if the claimant proved the compensable injury was a material contributing cause of a worsened condition, the employer then had the burden of proving that an off-the-job injury was the major contributing cause of the worsened condition in order to defeat the aggravation claim).

Based on the findings and reasoning expressed in the Referee's order, we are persuaded that claimant established a material relationship between his current condition and his 1989 compensable injury, and that the insurer failed to establish that the "Washington" injury was the major contributing cause of claimant's worsened condition. Consequently, we conclude that claimant's aggravation 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 is $900, 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 May 19, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $900, payable by the insurer.

In the Matter of the Compensation of
VENA K. MAST, Claimant
WCB Case No. 92-04030
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Gruber's order that: (1) decreased her scheduled permanent disability award from 20 percent (38.4 degrees), as awarded by an Order on Reconsideration, to zero; and (2) declined to assess a penalty pursuant to ORS 656.268(4)(g). The insurer cross-requests review of that portion of the Referee's order that assessed a penalty against it for its failure to pay permanent disability benefits due under an Order on Reconsideration within 30 days of its issuance. On review, the issues are extent of scheduled permanent disability and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

The Referee applied the standards in effect on the date of the January 13, 1992 Notice of Closure. (WCD Admin. Order 2-1991). On review, claimant contends she is entitled an to award for loss of pronation and loss of strength.

The Referee concluded that claimant was not entitled to an award for loss of pronation pursuant to former OAR 436-35-100(4), because that rule refers specifically to the elbow joint rather than the wrist joint. The Referee reasoned that Dr. Whitney, claimant's attending physician, did not relate the loss of pronation to the compensable injury.

On review, claimant contends that she is entitled to an award for loss of pronation because former OAR 436-35-080(9), which is located in the section of the standards dealing with impairment to the forearm (wrist joint), provides that pronation loss is determined pursuant to OAR 436-35-100. Considering that Dr. Whitney's finding of loss of pronation is contained in his closing report on claimant's bilateral carpal tunnel claim, (Ex. 17), we conclude, in the absence of any contrary evidence, that the finding of loss of pronation is due to the compensable condition. Accordingly, based on former OAR 436-35-080(9), we rate claimant's loss of pronation pursuant to former OAR 436-35-100. According to Dr. Whitney, claimant has 70 degrees of pronation bilaterally, therefore, under former OAR 436-35-100(4), claimant is entitled to an award of 2 percent scheduled permanent disability for each forearm.

After reviewing the record, we agree with the Referee that Dr. Whitney does not relate claimant's loss of strength to nerve injury, loss of muscle or disruption of the musculotendinous unit. Rather, Dr. Whitney related the strength loss to general deconditioning of the forearms. Therefore, we adopt the Referee's reasoning and conclusion that claimant is not entitled to an award of scheduled disability pursuant to former OAR 436-35-110(2).

Penalty Under ORS 656.268(4)(g)

The Referee concluded that a penalty pursuant to ORS 656.268(4)(g) was not appropriate. We agree.

ORS 656.268(4)(g) 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." (Emphases supplied.)

In Cynthia L. Luciani, 45 Van Natta 1734 (1993), we held that a penalty pursuant to ORS 656.268(4)(g) is available only if the requisite increase is awarded by the Department in its reconsideration order. Relying on the unambiguous language of the statute, particularly where emphasized above, we concluded that ORS 656.268(4)(g) was not applicable to increases in permanent disability that were awarded by a Referee or the Board. Id.

After further consideration of ORS 656.268(4)(g) and the statutory scheme, we continue to adhere to our reasoning in Luciani that the Department must award the requisite increase "upon reconsideration" in order for a penalty to be assessed under ORS 656.268(4)(g).

Although the language of ORS 656.268(4)(g) sets forth unambiguously the circumstances under which a penalty may be assessed under ORS 656.268(4)(g), it is silent regarding what happens to the penalty when, at hearing or on (Board or judicial) review, the permanent disability award upon which the penalty is based is reduced below the level for which a penalty may be assessed under ORS 656.268(4)(g). We have previously held that when a referee or the Board reduces a permanent disability award below the level for which a penalty may be assessed under ORS 656.268(4)(g), a penalty under that provision is not available. See Jerry E. Johnson, 45 Van Natta 280 (1993); Carl Smith, 44 Van Natta 1175, on recon 44 Van Natta 1471 (1992).

Thus, we have declined to construe ORS 656.268(4)(g) as a mandate for a carrier to pay a penalty assessed by the Department on reconsideration where the award upon which the penalty is based is subsequently reduced or disallowed at hearing or on review. The apparent intent of the penalty provision was to deter a carrier from "lowballing," i.e., closing a claim with an award of permanent disability benefits significantly below a claimant's entitlement. Testimony of Cecil Tibbetts, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B at 394. It is not consistent with that intent, however, to require a carrier to pay a penalty assessed by the Department based on an award to which the claimant was subsequently determined not to be entitled. We do not believe the legislature contemplated granting such a windfall to claimants.

The better approach, we believe, is to interpret ORS 656.268(4)(g) consistently with the remainder of the statute, particularly ORS 656.268(6)(b), which provides, in part: "If any party objects to the reconsideration procedure, the party may request a hearing under ORS 656.283 . . ." ORS 656.283(7) provides, in relevant part:

> "The referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

Under this statutory scheme, any party objecting to the Department's reconsideration order may request a hearing and establish before a referee that the permanent disability standards were incorrectly applied by the Department. If, after a hearing, a party still objects to the referee's decision, the party may request Board review. Again, on Board review, the party may establish that the standards were incorrectly applied by the Department. See ORS 656.289(3), 656.295(5).

Thus, the statutory scheme contemplates that the Director's reconsideration order shall be subject to review by the referee and the Board. It necessarily follows, therefore, that any penalty assessed by the reconsideration order is likewise subject to review by the referee and the Board. That is, if the Department awards permanent disability benefits and assesses a penalty based on the increased award, but a party requests a hearing concerning the reconsideration, both the permanent disability award and penalty assessments are subject to the referee's review. If the referee reduces the Department's permanent disability award below the level for which a penalty may be assessed under ORS 656.268(4)(g), the referee is authorized to reverse the penalty. If, on the other hand, the referee reduces the permanent disability award, but the award still qualifies for a penalty under ORS 656.268(4)(g), then the amount of the penalty shall be reduced proportionally to the award reduction, i.e., 25 percent of the reduced permanent disability award which is "then due." The Board likewise has the authority to reduce or reverse the penalty on review.

Here, the Department, on reconsideration, increased claimant's scheduled disability award from zero to 20 percent. Inasmuch as the award was increased by the Department by more than 25 percent and was greater than 20 percent, a penalty under ORS 656.268(4)(g) was assessable by the Department. However, the Department did not assess a penalty. Inasmuch as we lack authority to assess a penalty under ORS 656.268(4)(g), we agree with the Referee that no penalty may be assessed under that provision. Further, even if the Department had assessed a penalty, because claimant's permanent disability award has been subsequently reduced below the level for which a penalty may be assessed under ORS 656.268(4)(g), claimant would not be entitled to a penalty.

The dissent argues that we are "granting a 'windfall' to a carrier by not penalizing it for an inadequate award of permanent disability." The dissent misses the point of our holding. We are holding that, in those cases where a carrier's permanent disability award is ultimately determined to be adequate, no penalty should be assessed. In this case, for example, the insurer awarded no permanent disability; on review, we have awarded claimant 2 percent scheduled permanent disability for each arm. This is clearly not the case of "lowballing" with which the legislature was concerned. On the contrary, the insurer's award was very close to what we have ultimately concluded claimant's entitlement to be. In this and other similar cases, there is simply no justification for a penalty.

Penalty Under ORS 656.262(10)

The Referee assessed a penalty against the insurer for its allegedly unreasonable failure to pay a permanent disability award within 30 days of the Order on Reconsideration. The insurer contends that, since it appealed the Order on Reconsideration within 180 days of the date of the Notice of Closure, it properly stayed payment of the permanent disability award pursuant to ORS 656.313 and was not required to pay the permanent disability award within 30 days. On this basis, the insurer argues that a penalty was inappropriate. We disagree.

Subsequent to the Referee's order, in Pascual Zaragoza, 45 Van Natta 1221 (1993), we addressed the issue of when the insurer must file a request for hearing on an order on reconsideration in order to stay compensation under ORS 656.313(1). We held that for the insurer to take advantage of the stay provisions of ORS 656.313(1) and to avoid a penalty under ORS 656.262(10) for unreasonable delay or refusal to pay the benefits awarded, it was required to request a hearing within the time limitations set forth in OAR 436-60-150. Id. See also Gene G. Martin, 45 Van Natta 2102 (1993).

OAR 436-60-150(6)(c) provides that permanent disability benefits "shall be paid no later than the 30th day after the date of any department order which orders payment of compensation for permanent partial disability * * * benefits, unless the order has been appealed by the insurer pursuant to ORS 656.313."

Here, the Department's March 19, 1992 Order on Reconsideration awarded claimant permanent disability benefits. The insurer filed its cross-request for hearing more than 30 days after the date of the order. Thus, there were amounts of permanent disability benefits "then due" when the insurer filed the hearing request. See OAR 436-60-150(6)(c); Lydia L. Kent, 44 Van Natta 2438 (1992). We find, therefore, that the insurer unreasonably refused to pay the Order on Reconsideration award that became "then due." Accordingly, we affirm the Referee's penalty assessment. In reaching this decision, we note that claimant is not entitled to an attorney fee on review 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 November 20, 1992 is modified in part and affirmed in part. In lieu of the Order on Reconsideration award, claimant is awarded 2 percent (3.84 degrees) scheduled permanent disability for loss of use or function of the right arm and 2 percent (3.84 degrees) scheduled permanent disability for loss of use or function of the left arm. Claimant's counsel is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800. The remainder of the order is affirmed.

Board Members Gunn and Hall, dissenting:

The majority finds that claimant is not entitled to a penalty under ORS 656.268(4)(g) based on its reduction of claimant's permanent disability award. Because we believe this contravenes the clear language of ORS 656.268(4)(g), we dissent.

ORS 656.268(4)(g) mandates a penalty 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 disabled . . ." (Emphasis supplied). As we held in Cynthia L. Luciani, 45 Van Natta 1734 (1993), the emphasized language is unambiguous and provides for a penalty only if the Department awards the requisite increase. While some statutory provisions created by the 1990 amendments are ambiguous and open to interpretation, ORS 656.268(4)(g) could not be more clear. We do not believe that this provision requires anything other than an application of its clear language and that is where the inquiry should end.

The majority, however, finds that applying the clear language of ORS 656.268(4)(g) to this situation would be contrary to the statutory scheme envisioned by the legislature. Although we do not believe that resorting to the "statutory scheme" is necessary, our view of the legislature's intent differs from the majority.

The majority acknowledges that the apparent intent of ORS 656.268(4)(g) was to deter a carrier from "lowballing" awards of permanent disability whenever a carrier closed a claim rather than submitting it to the Department for closure. This intent is necessarily premised on the assumption that a carrier will obtain adequate medical evidence prior to issuing its Notice of Closure.

The majority's decision, however, loses sight of this fact. The legislature's concern was focused on whether the carrier performed its obligation in the first instance, not on the ultimate result of the case. By focusing on the end result, the majority allows a carrier the option of issuing a Notice of Closure without adequate medical evidence and then (in those cases where the worker contests that closure notice) supporting its Notice of Closure after the fact. This assumes that a worker has the inclination to go through oft-protracted litigation that accompanies the appeal of a closure order. Consequently, a carrier is allowed to gamble on the ultimate outcome of its closure, while at the same time delaying that outcome and withholding permanent disability benefits from the worker.

Finally, we believe the majority decision creates disparate results depending on whether the carrier or the worker is ultimately correct. Since it does not disavow Luciani, we assume the majority would still not allow a penalty under ORS 656.268(4)(g) when it is determined by a Referee or the Board that claimant is entitled to the requisite increase in permanent disability. However, the majority would reverse a penalty under ORS 656.268(4)(g) if it is determined by a Referee or the Board that claimant was not entitled to the requisite increase. While the legislature may not have contemplated granting a "windfall" to claimant, it surely did not contemplate granting a "windfall" to a carrier by not penalizing it when its initial award of permanent disability is determined to be inadequate by a Referee or the Board.

For these reasons, we dissent.

January 12, 1994 Cite as 46 Van Natta 38 (1994)

In the Matter of the Compensation of
WILBERT M. McDANIEL, Claimant
WCB Case No. 92-12648
ORDER ON REVIEW
Crispin & Associates, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Spangler's order that awarded 6 percent (9 degrees) scheduled permanent disability for loss of use or function of claimant's left forearm, whereas an Order on Reconsideration had awarded 28 percent (42 degrees). On review, the issue is extent of scheduled permanent disability.

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

The first sentence in the third full paragraph on page 3 is corrected to read: "Further, there is no persuasive evidence that claimant has a chronic left forearm condition, which is due to the compensable injury."

In addition, we acknowledge claimant's request for an impairment rating for injury-related surgeries. Assuming, without deciding, that the issue is properly raised on review, we conclude that no such rating is available under the standards. See former OAR 436-35-110(4).

ORDER

The Referee's order dated January 19, 1993 is affirmed.

Board Member Gunn dissenting.

Claimant has lost grip strength as a result of his compensable left wrist injury. His loss is measurable and it was measured. These facts are not disputed. Since the injury, claimant has undergone two left wrist surgeries as a result of his injury. Both operations involved cutting and resecting interosseous nerves (i.e., removing portions of them). Moreover, nerve conduction studies reveal that the injury impacted claimant's median and ulnar nerves as well. Claimant's ability to lift, grasp and effectively use the fingers of his left hand remains considerably less than before his injury, even after his surgeries. Under these circumstances, I believe that claimant should be compensated for his injury-related impairment including diminished strength, which certainly limits the use and function of his left forearm. See ORS 656.214(2).

However, under the applicable standards, claimant's lost grip strength is only ratable if there is medical evidence indicating that the loss is due to nerve damage. Specifically, the standards provide that loss of strength is rated when the cause is a peripheral nerve injury. "Peripheral" nerves apparently include only the median, radial, ulnar and musculocutaneous nerves. If this is true, the majority is correct that claimant's lost grip strength is not ratable under the standards. However, even assuming that is the case, claimant should nonetheless be compensated for his loss under ORS 656.726.

ORS 656.726(3)(f) provides that the Director is charged with providing standards for the evaluation of disabilities. In addition, the following provisions apply to the standards:

> "(A) The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job.
>
> "(B) Impairment is established by a preponderance of medical evidence based upon objective findings.
>
> "(C) 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, notwithstanding ORS 656.268, 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. * * * * * " ORS 656.726(3)(f)(A)-(C).

In the present case, claimant has satisfied the requirements of sections (A) & (B), above. In other words, he has proven injury-related lost strength (impairment), based on a preponderance of (uncontroverted) medical evidence and objective findings. The Director found, or should have found (upon reconsideration), that this worker's disability (lost grip strength) is not addressed by the standards. Under these circumstances, the Director should have stayed further proceedings on the reconsideration of the claim and adopted temporary rules amending the standards to accommodate the worker's impairment. See Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). This was not done in claimant's case.

In my view, the Director's duty under ORS 656.726(3)(f)(C) in this case was mandatory and clear, but not performed.[1] Under these circumstances, I do not believe that this worker should be treated differently from those whose impairments happen to be ratable under the standards. Others receive compensation for their injury-related permanent impairments, but claimant does not simply because the Director did not comply with the statute. Because I consider such a procedure to be unfair and contrary to the statute mandating that injury-related permanent disabilities be compensated, I respectfully dissent.

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[1] I direct the parties to my dissent in Gary D. Gallino, 44 Van Natta 2506, 2510-12 (1992), for a full discussion of the impact and legislative history of ORS 656.726(3)(f)(C). See also Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

In the Matter of the Compensation of
CLARENCE E. GOFF, Claimant
WCB Case No. C3-03077
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT AND WITHDRAWING ACKNOWLEDGEMENT LETTER
Kirkpatrick & Zeitz, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

On November 30, 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.

By order dated December 16, 1993, the Board disapproved the parties' CDA on the basis that the agreement contained language concerning a dispute between claimant and SAIF as to the compensability of nocturnal shaking episodes. Noting that the function of a CDA is to dispose of an accepted claim, we found that the CDA was unreasonable as a matter of law. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991).

On December 23, 1993, the parties resubmitted the CDA, indicating that the objectionable language had been removed. A letter accompanying the amended CDA stated that the parties wished to "proceed on this amended Claims Disposition Agreement." The letter did not specifically request that we reconsider our order pursuant to OAR 438-09-035(2). Accordingly, we treated the December 23, 1993 amended CDA as a new agreement and acknowledged the receipt of that agreement on December 23, 1993, which began a new 30-day waiting period.

Subsequently, it has come to our attention that the letter and revised CDA were intended as a request for reconsideration. Furthermore, after reviewing the letter and revised CDA, we find that the documents constitute a request for reconsideration and the total consideration to claimant has remained the same. Therefore, this matter is distinguishable from a case in which a claimant's 30-day waiting period must begin again following resubmission, due to a revision by the parties which substantially alters the amount of consideration underlying the bargain. See e.g. Mary A. Smith, 45 Van Natta 1072 (1993).

Thus, because the disapproval was mailed on December 16, 1993, and the parties' amended CDA was filed on December 23, 1993, we find the amended CDA was timely filed pursuant to OAR 438-09-035. Moreover, upon review of the amended CDA, we find good cause for allowing the additional submission. Accordingly, we withdraw our December 23, 1993 letter of acknowledgment, and we treat the parties' amended CDA as a request for reconsideration. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

The parties have submitted a modified CDA that specifically eliminates the reference to a dispute concerning compensability of nocturnal shaking episodes. Accordingly, on reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1).

This CDA is approved for a total consideration of $35,000, with $29,625 of the proceeds to be paid to claimant. An attorney fee of $5,375, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL K. BEVIER, Claimant
WCB Case No. 91-15953
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Livesley's order which: (1) dismissed his hearing request for lack of jurisdiction over the self-insured employer's "de facto" denial of prescription medications and medical treatment to monitor the medications; and (2) decined to assess a penalty and related attorney fee for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are jurisdiction, medical services, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation and modification.

Claimant began treating with Dr. Brown, psychiatrist, in October 1990. Dr. Brown prescribed Prozac for claimant's psychological condition, but claimant took the medication only intermittently because he could not afford to purchase the drug.

On April 30, 1991, the employer's processing agent declined to grant Dr. Brown's request for approval of palliative care under ORS 656.245(1)(b). (Ex. 2). Dr. Brown again requested approval from the carrier in May and September 1991. (Exs. 4, 5).

Dr. Brown did not request palliative care approval from the Director under ORS 656.245(1)(b). Neither the parties nor the Director requested Director review of claimant's treatment under ORS 656.327(1).

The employer did not issue a formal acceptance or denial of claimant's claim for prescription medications and medical treatment to monitor the medications within 90 days after it received notice of the claim.

We do not adopt the Referee's finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee found that the Hearings Division did not have jurisdiction to decide whether claimant is entitled to the medical services he seeks because this question involves a medical services dispute which is properly resolved by the proceeding contemplated in ORS 656.327(1). In so holding, the Referee relied on our decision in Stanley Meyers, 43 Van Natta 2643 (1991).

In Stanley Meyers, the claimant sought chiropractic treatment in excess of two visits per month. The insurer denied the claim, and the claimant requested a hearing. The Referee set aside the insurer's denial as procedurally improper, and held that the insurer was required to seek Director review under ORS 656.327(1). The claimant requested Board review. On review, we held that under ORS 656.704(3), "matters concerning a claim" over which the Board and its Hearings Division have original jurisdiction, do not include any dispute regarding medical treatment that is challenged on one of the grounds listed in ORS 656.327(1), i.e., "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services." We reasoned that, following the 1990 amendments to ORS 656.704, Director review of medical treatment disputes was a mandatory, rather than discretionary, procedure.

The court has recently reversed our decision in Stanley Meyers. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). The court held that the 1990 amendments to ORS 656.327(1) do not require the parties or the Director to invoke the Director review process. Instead, the court found that the 1990 amendments left untouched the parties' discretion to request Director review, or to seek resolution of a

ORS 656.327(1), the court held that if a party or the Director "wishes review of the treatment by the director," and gives notice, the statute provides the procedure, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. 123 Or App at 221-22. However, without a "wish" for Director review and appropriate notice, the court concluded that there is no "proceeding" before the Director. 123 Or App at 222. Reasoning that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create the jurisdiction occur, the court held that those conditions did not occur in Meyers. Accordingly, the court found that the medical treatment dispute remained within the Board's jurisdiction. Id.

Here, the medical treatment dispute concerns claimant's entitlement to prescription medications and office visits to monitor the medications. The employer contends that the requested treatment is palliative care, and since ORS 656.327 provides a proceeding for determining whether requested palliative care is compensable, the Director has exclusive jurisdiction over the issue.

In this case, however, neither party, nor the Director, sought Director review under ORS 656.327(1). Accordingly, pursuant to the Court of Appeals decision in Meyers v. Darigold, Inc., supra, we conclude that the Director did not have jurisdiction over this dispute under ORS 656.327.[1]

We next determine whether the Director had jurisdiction over this dispute under ORS 656.245. Claimant contends that the medical services at issue are curative rather than palliative, and therefore, are compensable under ORS 656.245(1)(a). Alternatively, claimant contends that the treatment is compensable palliative care under ORS 656.245(1)(b).

We have previously held that the Director has exclusive jurisdiction under ORS 656.245 to resolve disputes concerning whether palliative care is compensable under the criteria set forth in ORS 656.245(1)(b), i.e., whether palliative care is provided to a permanently and totally disabled worker or is necessary to monitor administration of prescription medication required to maintain the worker's medically stationary condition or to monitor the status of a prosthetic device. Douglas K. Johnson, 44 Van Natta 843 (1992). See also Robert D. Cox, 43 Van Natta 2726 (1991).

However, we believe the court's decision in Meyers undermines our holding in Johnson, inasmuch as the court held that the Director does not acquire exclusive jurisdiction of a medical services dispute unless the conditions necessary to create that jurisdiction occur. Under ORS 656.327, the Director acquires jurisdiction only if a party or the Director "wishes" Director review. In so holding, the court relied on the plain language of the statute. See Meyers, supra, 123 Or App at 221-22.

Following the reasoning in Meyers, we believe we must give effect to the plain language of ORS 656.245(1)(b) in determining whether the Director has exclusive jurisdiction over a palliative care dispute. ORS 656.245(1)(b) provides:

> "Notwithstanding paragraph (a) of this subsection, after the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. 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. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment."

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[1] This holding is consistent with the court's recent decision in Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993), which reversed our order in Gladys M. Theodore, 44 Van Natta 905 (1992), wherein we had held that the Director has exclusive jurisdiction to determine whether treatment is curative or palliative, without regard to whether any party sought Director review under ORS 656.327. In Theodore, the court held that the Director could have jurisdiction under ORS 656.327 over a dispute

Based on the plain language of ORS 656.245(1)(b), we conclude that one condition which must exist before the Director acquires exclusive jurisdiction over a palliative care dispute is that the treatment at issue must be "palliative care which would otherwise not be compensable under this paragraph." Absent this condition, there is no "procedure otherwise provided in this chapter," within the meaning of ORS 656.704(3), and the dispute remains a "matter concerning a claim" over which the Hearings Division has jurisdiction. ORS 656.704(3). This construction is consistent with the Director's rules regarding palliative care, which identify palliative care which is compensable and provide a procedure for obtaining Director approval of palliative care which would otherwise not be compensable. See OAR 436-10-041. Accordingly, we disavow our contrary holding in Douglas K. Johnson, supra.

Our statutory construction is consistent with the Court of Appeals' recent decision in Hathaway v. Health Future Enterprises, 125 Or App 549 (1993). In Hathaway, the court affirmed our holding that the Hearings Division lacks jurisdiction over a carrier's refusal to approve palliative care. The palliative care in that case did not meet the criteria in ORS 656.245(1)(b), i.e., provided to a permanently and totally disabled worker or necessary to monitor administration of prescription medication required to maintain the worker's medically stationary condition or to monitor the status of a prosthetic device. Therefore, the Hathaway court concluded that the procedure provided in ORS 656.245(1)(b) for the approval of otherwise noncompensable palliative care is the exclusive procedure available for contesting a carrier's decision not to approve palliative care. Accordingly, the court held that the palliative care dispute in that case is a matter within the Director's exclusive jurisdiction.

We emphasize that the dispute in Hathaway concerned palliative care which otherwise would not be compensable under ORS 656.245(1)(b). Inasmuch as the Hathaway dispute satisfied the precondition for the Director to obtain exclusive jurisdiction under ORS 656.245, it was properly a matter within the Director's exclusive jurisdiction.

Here, on the other hand, claimant asserts that, if the medical treatment at issue is palliative rather than curative, it is compensable palliative care under ORS 656.245(1)(b) because it is treatment "necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition." In other words, claimant is asserting that a precondition to the Director's exclusive jurisdiction under ORS 656.245 has not been satisfied in this case. If we agree with claimant, this dispute is a matter within our jurisdiction. Therefore, we must decide the merits of claimant's contention in order to determine whether we have jurisdiction to order payment of the disputed care.

In his appellate briefs, claimant requests that we remand this matter to the Referee for a full hearing on the merits. However, inasmuch as exhibits were admitted and testimony taken at the hearing, we consider the record to be fully developed. We find no evidence that the hearing was curtailed because the Referee believed he lacked jurisdiction to hear the matter. (See Tr. 4-5). Consequently, remand is unnecessary, and we proceed to the merits of the claim.

Medical Services

Claimant contends that the medications prescribed by Dr. Brown are compensable medical services under ORS 656.245(1)(a) and (c), and that office visits with Dr. Brown are compensable palliative care under ORS 656.245(1)(b), required to monitor the medications. We agree.

First, we address claimant's entitlement to prescription medications. It is claimant's burden to establish that the prescription medications are for a condition resulting from the compensable injury, and are "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1)(a); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993). In other words, claimant must establish that the medications are necessary, appropriate and related to his compensable injury in order for the medications to be reimbursable. See OAR 436-10-040(1)(a).

Dr. Brown, claimant's treating psychiatrist since October 1990, prescribed the medications Prozac and Desyrel for the treatment of claimant's depression. (See Ex. 6). Claimant's psychological condition has been determined to be a compensable part of his claim arising from his original 1987 neck injury. (See Ex. 1-2). The employer does not challenge the compensability of the psychological condition being treated by Dr. Brown, nor does it contend that claimant's need for medication is unrelated to his psychological condition.

Dr. Brown testified that in his opinion, claimant's depression would at least remain stationary if he is maintained on Prozac, supplemented with another medication. (Ex. 10-52). Indeed, he believed that claimant's psychological condition would improve with medications. (Id; see also Ex. 10-15 to -17). He also stated that when claimant stopped taking Prozac, his psychological condition deteriorated. (Ex. 10-52 to -53). Dr. Brown anticipated that claimant's depression would improve with the administration of Prozac for a period of six months, possibly supplemented with another medication. (Ex. 10-32 to -33). He further testified that the standard medical recommendation is to continue medications for at least one year after the patient has reached an improved state, in order to prevent recurrence of depression. (Ex. 10-38). Finally, Dr. Brown testified that, without medications for his depression, the quality of claimant's work deteriorates; indeed, at the time of the hearing, he was only marginally employable. (See Ex. 10-41 to -42, -44, -54).

There is no contrary medical opinion in the record. Accordingly, we conclude, based on Dr. Brown's opinion, that the medications prescribed by Dr. Brown are necessary and appropriate for the treatment of claimant's compensable depression.

Moreover, to the extent that the employer contends that claimant's prescriptions are noncompensable palliative care, we reject that position. Although ORS 656.245(1)(b) does not expressly provide that prescription medications are compensable, that conclusion is implicit in the provision that allows palliative care "when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition," without prior approval by the Director. See also Department Bulletin No. 229 (February 22, 1991) (prescription medications remain a covered benefit and do not require prior approval under the palliative care provisions of OAR 436-10-041).

Next, we consider whether Dr. Brown's office visits are compensable. If the office visits are necessary to monitor the administration of prescription medication required to maintain the worker in a medically stationary condition, they constitute compensable palliative care. ORS 656.245(1)(b). Such care is compensable without prior approval by the carrier. See OAR 436-10-041(1)(b).

Dr. Brown explained that it is necessary to monitor the medications he has prescribed for claimant. (Ex. 10-53). In order to monitor the medications, Dr. Brown has been seeing claimant an average of once per month. (Ex. 10-14). The monitoring consists of a psychiatric interview to determine whether there has been improvement and whether there are side effects to the medications; in addition, Dr. Brown monitors interaction with other medications claimant may be taking. (Id). There is no contrary medical opinion regarding the necessity for monitoring the medications.

We find, based on Dr. Brown's testimony, that the office visits are necessary to monitor administration of the prescription medications which are necessary to maintain claimant in at least a medically stationary condition. Accordingly, we find the office visits to be compensable palliative care under ORS 656.245(1)(b).

Because we have found the requested treatment to be compensable palliative care under ORS 656.245(1)(b), we conclude that the Director could not acquire jurisdiction over this dispute. Therefore, we find that the issue before the Referee was a "matter concerning a claim" over which the Board and its Hearings Division have jurisdiction. Accordingly, we order the employer to pay for the disputed prescription medications and office visits.

Penalties and Attorney Fees

Claimant asserts that he is entitled to a penalty and related attorney fee under ORS 656.262(10) because the employer's failure to process his claim for medical services constituted an unreasonable delay or refusal to pay compensation. We agree that the employer's conduct was unreasonable.

On October 31, 1990, the employer's processing agent wrote to Dr. Brown, acknowledging that it had received his billings, and requested information regarding the purpose for Dr. Brown's palliative care. (Ex. 10 - Deposition Ex. B). On April 30, 1991, the processing agent responded to Dr. Brown's letter, declining to grant his request for approval of palliative care; however, it issued no formal denial of the requested medical services. (Ex. 2). Dr. Brown again requested approval for "palliative care" from the processing agent in May and September 1991, and on October 7, 1991, he wrote to the processing agent explaining claimant's need for medications. (See Exs. 4, 5, 6). There is no evidence that the processing agent responded to Dr. Brown, and as of August 27, 1991, Dr. Brown's bills for treatment dating from October 18, 1990 to July 11, 1991 remained unpaid. (Ex. 7).

We find that at least by October 7, 1991, the processing agent was aware, or should have been aware, that the requested medical treatment consisted of prescription medications for an accepted condition and office visits to monitor the medication. (See Ex. 6). We also find that the employer had no basis for a legitimate doubt regarding the compensability of the treatment, since Dr. Brown's opinion was not controverted. We further find that, although the amendments to ORS 656.245 which became effective on July 1, 1990 may have resulted in some confusion regarding the compensability of prescription medications, by February 22, 1991, the processing agent should have been aware of the Director's rules regarding reimbursement for prescription medications. See Department Bulletin No. 229, supra.

Accordingly, we find that at least by the February 1992 hearing, the processing agent's continued failure to process claimant's claim for prescription medications and office visits to monitor the medications as required medical treatment and compensable palliative care under ORS 656.245(1)(a) and (b) constituted an unreasonable delay or refusal to pay compensation. We further find that the employer apparently did not contest the compensability of the requested treatment, since it neither denied the treatment as being unrelated to an accepted condition, nor did it request Director review of the appropriateness of the treatment. Under these circumstances, we find that the employer's inaction constituted unreasonable claims processing.

We have found that the medications prescribed by Dr. Brown and his treatment to monitor the medications are compensable medical services for a previously accepted condition. Therefore, we find that the employer's unreasonable claims processing constituted an unreasonable delay or refusal to pay compensation, for which a penalty may be assessed under ORS 656.262(10). See Opha D. Richard, 44 Van Natta 1229, 1231 (1992); Clinton F. Seals, Jr., 42 Van Natta 268, 269 (1990) (cost of medical benefits for an accepted condition is "compensation" for purpose of calculating a penalty on "amounts then due" under ORS 656.262(10)). Accordingly, we assess a penalty in the amount of 25 percent of medical benefits (prescription medications and office visits) due at hearing as a result of this order, payable by the self-insured employer. The penalty shall be paid in equal shares to claimant and his attorney. ORS 656.262(10).

ORDER

The Referee's order dated January 19, 1993 is reversed. Claimant's request for hearing is reinstated. The self-insured employer's "de facto" denial is set aside, and the claim for medical services is remanded to the employer for processing in accordance with law. The self-insured employer is assessed a penalty in the amount of 25 percent of medical benefits due at hearing as a result of this order, payable by the self-insured employer. The penalty shall be paid in equal shares to claimant and his attorney.

January 13, 1994 Cite as 46 Van Natta 45 (1994)

In the Matter of the Compensation of
BARBARA J. COLLINS, Claimant
WCB Case No. 92-05528
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of that portion of Referee Mongrain's order which set aside its denial of claimant's claim for allergic bronchospasm (asthma). On review, the issue is compensability.

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

At the outset, we note that claimant has moved to strike those portions of the employer's appellant's brief that refer to Exhibit 13, which was not admitted into evidence. In its reply brief, the employer withdrew its references to Exhibit 13. Therefore, we need not rule on claimant's motion.

Although the parties framed the compensability issue in terms of an occupational disease, the Referee held that claimant's pulmonary claim was compensable as an industrial injury. He found that the medical evidence established that claimant's work exposure over the course of a few hours on February 26, 1992, was "a material contributing cause of her increased symptoms that required medical treatment." The employer contends that the Referee erred in analyzing the claim as an accidental injury, when the parties litigated the claim as an occupational disease. We do not agree.

The employer's denial was a general denial of either an accidental injury or an occupational disease. Specifically, it denied claimant's "claim" for heat exhaustion, stress, and allergic bronchospasm. Claimant appealed the denial and her request for hearing raised the issue of "compensability." This raised both the theory of accidental injury, as well as occupational disease. See Linda D. Renalds, 45 Van Natta 2243 (1993). Although claimant's counsel initially described the issue as compensability under the occupational disease statute, he later described the issue as whether or not claimant's work exposure resulted in "in any kind of a compensable condition." (Tr. 120). Moreover, the accidental injury theory underlying the Referee's decision in this case was not a new issue, but rather an alternative legal theory on the compensability issue claimant raised in her request for hearing. See Allen B. Cooper, 40 Van Natta 1915, 1916 (1988). For these reasons, the Referee did not err in analyzing the claim as an accidental injury.

The employer also contends that, even assuming the Referee correctly analyzed the claim as one for an accidental injury, a major contributing cause analysis should still have been applied because claimant had a preexisting pulmonary condition. See ORS 656.005(7)(a)(B). The employer cites claimant's testimony that she has had symptoms for approximately two years and that her complaints came on gradually as evidence of a preexisting pulmonary condition.

Assuming arguendo that the claim should have been analyzed as an accidental injury claim involving a preexisting condition, thus requiring a major contributing cause analysis, we would still find that claimant has established a compensable pulmonary claim. We agree with the Referee's reasoning regarding the persuasiveness of the medical opinions expressed in this claim but would add the following comments regarding the medical evidence.

Claimant's treating physician, Dr. Baker, opined that claimant's work exposure was the major contributing cause of her pulmonary condition diagnosed as allergic bronchospasm. (Ex. 10). Absent persuasive reasons to do otherwise, we generally defer to the opinion of the attending physician. Weiland v SAIF, 64 Or App 810 (1983).

In addition, Dr. Bilder, claimant's consulting physician, concurred with Dr. Baker's analysis. (Ex. 10). Although the employer's pulmonary expert, Dr. Vance, testified that Dr. Bilder's reputation in the medical community was poor, we agree with the Referee that his opinion is entitled to at least some weight.

More importantly, Dr. Vance's testimony does not cause us to discount the opinions offered by Drs. Baker and Bilder. Although Dr. Vance testified that Dr. Bilder's pulmonary function tests were normal, he stated that a correct diagnosis of asthma could be made in a substantial number of instances even in the absence of pulmonary function tests. (Tr. 145). He also could not preclude the possibility that Dr. Baker and Dr. Bilder had accurately diagnosed asthma based solely on claimant's clinical symptoms. (Tr. 148).

Regardless of whether this claim is analyzed as an accidental injury or as an occupational disease, as the employer contends that it should have been, we conclude that claimant has proved a compensable pulmonary claim. The preponderance of the medical evidence establishes that claimant's work exposure is the major contributing cause of the onset or worsening of claimant's pulmonary condition in February 1992, requiring medical treatment.

Finally, the employer asserts that the Referee's order does not reasonably define what it has been ordered to accept. The Referee's order remands the claim for acceptance of "treatment related to the claimant's respiratory symptoms in February, 1992." The Referee's order is sufficiently clear. If the employer believes that certain medical treatment is not related to claimant's compensable pulmonary condition, then it is free to issue a partial denial of such treatment.

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

ORDER

The Referee's order dated April 5, 1993, as supplemented on April 6, 1993, is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the self-insured employer.

In the Matter of the Compensation of
GLENDA R. LINDERMAN, Claimant
WCB Case No. 92-14203
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of those portions of Referee Davis' order that: (1) found that claimant's low back injury claim was not prematurely closed; and (2) affirmed the Order on Reconsideration which awarded no permanent disability. On review, the issues are premature closure and extent of unscheduled permanent disability.

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

On review, claimant argues that the opinions of Dr. Lee, attending physician, establish that claimant was not medically stationary at claim closure. (Exs. 61, 62). We agree with the Referee's analysis of those opinions. Although stating that claimant was not and had not been medically stationary, Dr. Lee also stated that no further treatment was available and that any future treatment would be palliative in nature.

Furthermore, Dr. Lee did not opine that there was a reasonable expectation of further material improvement with the passage of time. ORS 656.005(17). Instead, he merely stated that "about two months of time passage is necessary to determine whether [claimant] is medically stationary." (Ex. 61). Claimant argues that Dr. Lee's statement means that "he needs that period of time to determine if the objective findings indicate [claimant's] condition has stabilized." That interpretation is very close to the Referee's interpretation that Dr. Lee merely stated that he needed a couple of months to "see what happens." In any event, even if we found claimant's argument persuasive, it does not apply the correct legal standard. The fact remains that Dr. Lee did not opine that there was a reasonable expectation of material improvement with the passage of time. ORS 656.005(17).

In the alternative, claimant argues that she is entitled to an award of unscheduled 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. Conner, 43 Van Natta 1544, corrected 44 Van Natta 1567 (1992). Here, claimant did not disagree with the findings used in rating her disability at claim closure and no medical arbiter was appointed. (Ex. 62A).

Citing Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992), claimant contends that her impairment must be determined as of the date of claim closure. Therefore, she argues, we must rely on Dr. Lee's chart notes as of that date to determine her disability rather than the findings listed in his September 5, 1992 report.

Claimant misreads our discussion in Vickie M. Libel, supra, regarding the date of determination of impairment. In Libel, we held that, in evaluating claimant's disability (excluding permanent impairment), the disability is determined as of the mailing date of the determination order. In any

event, our holding regarding the time to determine non-impairment disability factors has since been overturned by the Court of Appeals. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In Smith, the court held that, pursuant to ORS 656.283(7), evaluation of a worker's disability shall be as of the date of the issuance of the reconsideration order under ORS 656.268. In addition, the court concluded that this evaluation of disability includes the claimant's adaptability factor. Thus, all disability factors, including impairment, shall be determined as of the date of the reconsideration order. ORS 656.283(7); Safeway Stores, Inc. v. Smith, supra.

Dr. Lee's September 5, 1992 report evaluates claimant's impairment closest to the time of the October 22, 1992 reconsideration order.[1] Furthermore, we agree with the Referee's analysis of that report and his conclusion that claimant's ranges of motion are normal.

Finally, claimant argues that she is entitled to an impairment rating based on her inability to repetitively use her low back. OAR 436-35-320(5) provides:

> "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. 'Body area' means the cervical/upper thoracic spine (T1-T6)/shoulders area and the lower thoracic spine (T7-T12) lowback/hips area. Chronic conditions in the middleback are considered a part of the lowback/hips body area."

In Donald E. Lowry, 45 Van Natta 1452 (1993), the Board interpreted OAR 436-35-010(6), the rule regarding scheduled chronic condition impairment, to require medical evidence of at least a partial loss of ability to repetitively use the body part. Other than the listing of the "body parts/body areas," the language of the two rules is identical. Therefore, based on the reasoning in Lowry, we find that establishment of an unscheduled chronic condition impairment requires medical evidence of at least a partial loss of ability to repetitively use the body area.

Claimant relies on chart notes and reports from Dr. Lee in support of her argument that she has an unscheduled chronic condition impairment. (Exs. 50A, 61A, 62). We do not find that Dr. Lee's opinions establish a chronic condition impairment. Dr. Lee repeatedly recommended that claimant sustain or increase her work hours, although he noted that claimant reported that her subjective pain often kept her from working. (Exs. 50A-2, -3, -5, 62). Although mentioning a work capacity evaluation performed by a therapist at the time of the IME, Dr. Lee did not adopt or concur with that evaluation. (Ex. 62-1). Furthermore, Dr. Lee does not state that claimant has a partial loss of ability to repetitively use her low back, nor does he make findings from which we can conclude that claimant has such a loss. Therefore, on this record, claimant failed to prove an unscheduled chronic condition impairment.

ORDER

The Referee's order dated March 12, 1993 is affirmed.

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[1] We note that Exhibits 61 and 62 were written after issuance of the July 23, 1992 Notice of Closure, as amended on August 5, 1992, but before issuance of the October 22, 1992 Order on Reconsideration. We have previously held that a medical report which is written or ratified by an attending physician after claim closure (and before the reconsideration proceeding) may be considered only if it qualified under ORS 656.268(5) as a corrective report or is "medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." Kristine M. Trump, 45 Van Natta 1268 (1993); Mark A. Pendell, 45 Van Natta 1040 (1993).

Recently, however, the Court of Appeals has held that, although the evidence that may be submitted on reconsideration before the Department of Insurance and Finance is limited by ORS 656.268(5), under ORS 656.283(7) the evidence that may be submitted at a hearing before a referee is not so limited. Safeway Stores, Inc. v. Smith, supra.

We applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report from the attending physician, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7), 656.283(7) were applicable. Id. Here, since the attending physician prepared the reports, there is no other basis to deny the admission of Exhibits 61 and 62. Therefore, pursuant to Smith and Luciani, the Referee in this case had the authority to consider those exhibits. Phillip A. Mullins, 45 Van Natta 1794 (1993).

In the Matter of the Compensation of
RONALD J. LOMBARD, Claimant
WCB Case No. 92-15759
ORDER ON REVIEW (REMANDING)
Kirkpatrick & Zeitz, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that porton of Referee McCullough's order that affirmed the Director's order under ORS 656.327(2) which found a proposed surgery to be inappropriate. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSION OF LAW AND OPINION

The Referee held that the Director's order concluding that proposed right shoulder surgery for claimant was inappropriate was supported by substantial evidence. The Referee therefore affirmed the Director's order. See ORS 656.327(2).

Claimant contends that the Referee and the Director failed to address the issue of whether or not the proposed surgery was appropriate as a diagnostic procedure. We find it unnecessary to address claimant's contention because the Director's order issued without statutory authority.

ORS 656.327(1) provides for review by the Director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services[.]" Subsequent to the Referee's order, in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time Director review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment. Moreover, the court determined that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 466-67.

Here, the dispute pertains to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, supra, the Hearings Division had jurisdiction to resolve the dispute concerning the proposed surgery.

No testimony was presented at the hearing and the documentary evidence consisted of the record considered by the Director. See Iola Payne-Carr, 45 Van Natta 335 (1993); but see Julie Sturtevant, 45 Van Natta 2344 (1993) (Iola Payne-Carr disavowed. Where a hearing is held under ORS 656.327(2), the parties may present additional evidence including testimony.) Thus, it is apparent that the parties were presenting their respective positions under the "substantial evidence" standard of review of ORS 656.327(2). See Patricia D. Simmons, 45 Van Natta 2305 (1993).

We may remand a case to the Referee if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). While a mere change in the law does not automatically merit remand, given the posture of this case (the parties' submission of the case based solely on the Director's record) and the court's and Board's recent holdings, we find a compelling reason to remand in this instance. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Jeanette E. Bollingberg, 45 Van Natta 2439 (1993); Peter Britz, 45 Van Natta 2187 (1993). Consequently, we conclude that the record is incompletely and insufficiently developed. See ORS 656.295(5). Therefore, we remand this case to the Hearings Division for further proceedings.

Accordingly, the Referee's order dated June 2, 1993 is vacated. We remand to Referee McCullough to conduct further proceedings in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective positions regarding the medical services dispute. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOANNA E. MALLY, Claimant
WCB Case No. 92-15833
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
James W. Moller (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Barber's order that declined to award additional temporary total disability from April 26, 1990 to July 20, 1990. On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation. We do not adopt his ultimate finding of fact.

On April 26, 1990, Dr. Lorish performed a medical examination at SAIF's request. He stated: "From the standpoint of her back surgery, I would say [claimant] is medically stationary. In addition, I think she is in all likelihood medically stationary in terms of her abdominal surgery, although Dr. Strandberg and Dr. Sullivan could better answer that question." (Ex. 4F-3). On May 24, 1990, Dr. Noall, claimant's attending physician, concurred in this opinion. (Ex. 4J).

On September 11, 1990, Dr. Noall issued a report in which he opined that claimant was medically stationary on July 20, 1990. He stated:

> "In answer to your letter of August 30, 1990, [claimant] has had laminectomy with single discectomy at L4-5. She did not have a facetectomy.
>
> "* * * *
>
> "* * * *
>
> "She became medically stationary on July 20, 1990; however, she developed an acute facet syndrome which I think is primarily related to the fact she had had a herniated disc and laminectomy. This required further treatment with physical therapy and usually requires a total of six weeks time to resolve." (Ex. 13A).

On January 2, 1992, after reviewing claimant's medical records, Dr. Sullivan gave his opinion regarding claimant's medically stationary date.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was barred by res judicata from litigating her entitlement to additional temporary disability and, alternatively, that she was not entitled to additional temporary disability on the merits. Claimant contends that res judicata does not apply to her pelvic condition, and that, therefore, she is not precluded from establishing her entitlement to additional benefits. We affirm the Referee's opinion, but for the following reasons.

A claimant's substantive entitlement to temporary disability benefits for her claim is established by a Determination Order or Notice of Closure. See generally ORS 656.268. Here, because claimant's pelvic condition claim had not been closed at the time of the November 1990 hearing on a Determination Order closing the low back portion of her claim, the issue of her substantive entitlement to temporary disability benefits based on her pelvic condition was not ripe for adjudication at that time.

Consequently, claimant was not barred by res judicata from litigating her entitlement to temporary disability based on the pelvic condition.[1]

SAIF closed claimant's pelvic condition claim by a July 13, 1992 Notice of Closure that awarded no permanent disability and no additional temporary disability benefits beyond those granted by the June 28, 1990 Determination Order. As noted above, this Notice of Closure determines claimant's substantive entitlement to temporary disability benefits for her pelvic condition claim. 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).

The June 28, 1990 Determination Order apparently relied on the opinion of Dr. Lorish, who examined claimant on April 26, 1990. He stated: "From the standpoint of her back surgery, I would say [claimant] is medically stationary. In addition, I think she is in all likelihood medically stationary in terms of her abdominal surgery, although Dr. Strandberg and Dr. Sullivan [who treated her pelvic condition] could better answer that question." (Ex. 4F-3). On May 24, 1990, Dr. Noall, claimant's attending physician, concurred in this opinion. (Ex. 4J).

Dr. Sullivan opined in a January 2, 1992 letter that claimant had been medically stationary and ready to be released for work by January 30, 1990, in regard to her pelvic condition. He noted, however, that claimant's back, which was being followed by Dr. Noall, prevented her from returning to work at that time. (Ex. 21).

In his September 11, 1990, report, Dr. Noall indicated that claimant's correct medically stationary date was July 20, 1990. However, that report referred only to claimant's low back condition, not to her pelvic condition.

Claimant has provided no evidence that any of her treating physicians reasonably expected her pelvic condition to materially improve from medical treatment or the passage of time subsequent to the April 26, 1990 examination. Consequently, we conclude that claimant was medically stationary in regard to her pelvic condition as of April 26, 1990. ORS 656.005(17); Harmon v. SAIF, supra.

ORDER

The Referee's order dated March 23, 1993 is affirmed.

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[1] Claimant does not contend that she is entitled to additional temporary disability compensation based on the low back portion of her claim. Furthermore, even if she had made that argument, it would fail. A June 28, 1990 Determination Order closed claimant's low back claim awarding temporary and permanent disability. Claimant requested a hearing from this closure order on the sole issue of the extent of permanent disability for the low back. A November 30, 1990 Opinion and Order issued, increasing claimant's unscheduled permanent permanent disability award. Claimant did not request review of this order. Therefore, it became final by operation of law. Consequently, claimant is barred from now raising the issue of additional temporary disability compensation for the low back by the doctine of res judicata. Drews v. EBI Companies, 310 Or 134, 140 (1990).

In the Matter of the Compensation of
LINDA J. MASDONATI, Claimant
WCB Case No. 92-00524
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Hazelett's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

Reasoning that claimant's 1987 compensable thoraco-lumbar sprain was not the major contributing cause of claimant's current low back condition and need for treatment, the Referee held that claimant's aggravation claim was not compensable. We agree with the Referee's conclusion.

The medical evidence establishes that claimant's current condition is the result of a combination of her compensable thoraco-lumbar strain and a preexisting degenerative condition. Claimant's attending physician, Dr. Takacs, opined that claimant's low back strain was "laminated" over her preexisting and underlying degenerative joint disease. (Ex. 6-6, 6-20). This opinion is supported by other medical evidence in the record. Dr. Mead, a consulting physician, diagnosed arthritic changes in claimant's left sacroiliac joint. (Ex. 13A). Dr. Berkeley, neurosurgeon, noted degenerative changes in the left facet joint at L5-S1. (Ex. 26A-3).

ORS 656.005(7)(a)(B) requires that the original compensable injury remain the "major contributing cause" of claimant's disability or need for treatment when, such as in this case, the compensable injury combines with a preexisting disease or condition. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). For the reasons expressed by the Referee, we find that the medical evidence does not establish that claimant's original injury remains the major contributing cause of her need for medical treatment for her resultant condition. Consequently, claimant's current low back condition is not compensable.

Claimant contends that that her compensable condition has worsened. However, claimant must prove the compensability of her condition, i.e., the requisite causal connection between her original injury and her current low back condition, before the issue of a compensable worsening is considered. Gray v. SAIF, 121 Or App 217 (1993). She has not done so. Therefore, her aggravation claim is not compensable.

ORDER

The Referee's order dated May 3, 1993 is affirmed.

In the Matter of the Compensation of
DONALD L. MYERS, Claimant
WCB Case No. 92-06885
CORRECTED ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Westerband, Haynes and Gunn.

Claimant requests review of Referee Tenenbaum's order that upheld the self-insured employer's denial of claimant's medical services claim for his current low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to establish that the 1975 injury was the major contributing cause of his L4-5 condition. We agree, based on the following reasoning.

Claimant's compensable injury in 1975 was diagnosed as a lumbar sprain. His claim was accepted by the employer as a disabling injury. Claimant's current condition, however, is a disc herniation at L4-5. Accordingly, because claimant's L4-5 disc condition has never been accepted by the employer, he must establish compensability of that condition. See Curtis H. Endicott, 45 Van Natta 1119 (1993)(The claimant did not have a herniated disc when his claim was accepted and his accepted condition did not directly cause his disc herniation. Under the circumstances, the claimant was required to establish that the accepted condition was the major contributing cause of his current condition.)

Here, the evidence does not establish that claimant's compensable 1975 injury was the direct cause of his current disc herniation condition. Therefore, claimant must establish that the 1975 lumbar strain is the major contributing cause of his current disc condition at L4-5. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperio, 113 Or App 411 (1992).

The relationship, if any, between claimant's current condition and his 1975 back strain injury 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). Accordingly, we review the medical evidence in the record.

In March 1992, Dr. Thompson conducted a record review for the employer. He opined that the major contributing factor in claimant's disc herniation was "the natural progression of degenerative disk disease in the lumbar spine and not in any way related to the injury of 1975 or 1976."

In July 1992, Dr. Mason, the surgeon who operated on claimant's L4-5 condition in 1991, stated that he believed that the 1975 injury was a contributing cause to claimant's changes at L4-5. However, Dr. Mason also reported that he could not "be certain whether the injury of 1975 is the major contributing cause to the changes occurring at the L4-5 level."

Dr. Cohen, claimant's original treating physician, reported on August 4, 1992 that it was "probable the injury of the intervertebral disk at L4-5 and L5-S1 occurred during the period he worked at (the employer)."

Finally, Dr. Ward, who examined claimant on referral from Dr. Mason, stated that he could not provide an objective opinion as to whether or not claimant's 1975 work accident was the major cause in "the development of the lumbar discopathy at L4-5 diagnosed and in his recent and current need for treatment of this condition."

After reviewing the medical evidence, we find that claimant has failed to establish that the 1975 injury is the major contributing cause of his current L4-5 condition and his need for treatment. Although Dr. Mason's opinion arguably supports a finding that claimant's injury is a material contributing cause, it does not establish that the injury is the major cause of the current condition. The

only remaining opinion in support of a causal relationship is that of Dr. Cohen. Although "magic words" are not required, we agree with the Referee that Dr. Cohen's opinion does not establish that the 1975 injury is the major cause of claimant's L5-4 condition.

Accordingly, we find that claimant has failed to establish compensability of his current L4-5 condition. Therefore, we affirm the Referee's order.[1]

ORDER

The Referee's order dated February 19, 1993 is affirmed.

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[1] In Beck v. James River Corp., 124 Or App 484 (1993), the court applied the "material contributing cause" test to a claim for medical services. We find the facts of the present case to be distinguishable. In Beck, the court stated that ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability, i.e. to claims for new injuries or conditions different from a previously accepted claim. The Beck court further stated, however, that the statute did not apply to a claim for "continued medical treatment of a compensable condition under ORS 656.245(1)." Beck, supra.

Here, claimant is seeking treatment for a ruptured disc at L4-5, a condition which had never been accepted. Thus, to obtain compensation for the condition, including medical services, claimant must establish compensability of the condition. Accordingly, this case does not involve continuing medical services under ORS 656.245(1) for claimant's compensable condition (his 1975 lumbar strain), and Beck, supra, does not apply.

Board Member Gunn dissenting.

The majority has held that Beck v. James River Corp., supra does not apply to this case, and claimant is required to prove compensability pursuant to ORS 656.005(7)(a)(A). I respectfully disagree on both counts.

In Beck, the court expressly stated that ORS 656.005(7)(a) (and therefore, ORS 656.005(7)(a)(A) and (a)(B)) does not apply to a claim for continued medical treatment of a compensable condition under ORS 656.245(1). Here, although claimant's 1975 low back injury is in "own motion" status, claimant remains entitled to medical services related to the compensable injury.

Dr. Mason, M.D., is the surgeon who operated on claimant's low back condition in 1987 and 1991. After reviewing claimant's records since the 1975 injury, Dr. Mason stated that his feeling was that "the original injury of 1975 is certainly one of the contributing factors to the disc changes at the L4-5 level."

Additionally, Dr. Cohen, claimant's original treating physician in 1975, re-examined claimant in August 1992. After reviewing claimant's history, Dr. Cohen noted that claimant never completely recovered from the 1975 injury, "for there was always back pain and weakness of the low back." Dr. Cohen opined that it was "probable the injury of the intervertebral disc at L4-5 and L5-S1 occurred during the period he worked at (the employer's)."

After reviewing the thorough and well-reasoned reports of Drs. Mason and Cohen, I must disagree with the majority's opinion that claimant's L4-5 condition is a "new injury or condition different from an already accepted claim." Here, the persuasive medical evidence establishes that claimant's current problems are a continuation of his 1975 compensable injury. The opinions expressed by Drs. Mason and Cohen are also consistent with claimant's testimony, which establishes that, due to his continuing and persistent back problems, he could not return to work with the employer. Claimant has modified his physical activities since the 1975 injury and has continued to experience problems, regardless of the intervening surgery.

Therefore, I conclude that Beck applies, and this claim for medical services is compensable as claimant has established that his need for treatment is, at least, materially related to the compensable 1975 injury.

In the Matter of the Compensation of
BERTHA PANIAGUA, Claimant
WCB Case No. 92-00275
ORDER ON REMAND
Michael B. Dye, Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993). The court reversed our prior order wherein we declined to address whether the insurer had given claimant the notice required by former OAR 436-30-035(7) before requesting and obtaining claim closure under that rule. Bertha Paniagua, 44 Van Natta 2289 (1992). Rather than decide the notice question, the Board reviewed the medical reports and determined that claimant was medically stationary at the time of claim closure. On appeal, the court reversed and remanded for reconsideration, pursuant to the insurer's concession that the Board had erred by failing to decide whether the notice given claimant was adequate for claim closure under former OAR 436-30-035.

On reconsideration of the matter, we affirm and adopt the Referee's order, with the following supplementation.

As the Referee explained, to be entitled to claim closure based on a presumption that the claimant is medically stationary, the notice given by the insurer must be in strict compliance with former OAR 436-30-035. We agree with the Referee's conclusion that claim closure was not appropriate in this case, because the notice given by the insurer was inadequate to trigger application of the presumption.

Whether a worker is "medically stationary" is, by virtue of the term's definition, a medical question that requires medical evidence. ORS 656.005(17). The administrative rule at issue here allows one exception to the medical evidence requirement. The rule essentially provides, in relevant part, that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, provided that the insurer has notified the worker that claim closure would occur due to the worker's failure to seek medical treatment.

The purpose of this rule is not to penalize the worker for failing to see his or her doctor. Rather, obtaining appropriate medical treatment furthers a core purpose of the Workers' Compensation Law: "to restore the injured worker physically and economically to a self-sufficient status in an expeditious manner." ORS 656.012. Furthermore, by seeking medical treatment, the worker thereby enables the insurer to have access, upon request, to the well-informed opinion of the treating physician concerning the worker's status for purposes of determining whether the claim should be closed. Where the worker fails to treat with his doctor after having received specific notice that his claim will be closed for that failure, the rule appropriately allows the claim to be closed based on a presumption that if the worker needed medical treatment, he would have sought medical treatment. However, to achieve the rule's legitimate purposes, the notice given must clearly and plainly state that the claim will be closed if claimant fails to return to her doctor for treatment.

Here, the insurer's letter, when read as a whole, basically says that if claimant or her doctor does not contact the insurer within two weeks, the claim will be closed. We agree with the Referee's conclusion that the notice given was inadequate to allow claim closure based on a presumption that claimant was medically stationary.

We also conclude that the record is inadequate to justify claim closure based on the medical evidence. First, we note that the insurer has never contended that claimant should or can be found medically stationary based on the medical evidence. Instead, the insurer sought and obtained closure under former OAR 436-30-035 based upon a presumption to which it was not entitled. Accordingly, it was error for the Board to have based its original order on its review of the medical evidence, particularly where, as here, the last word from the treating physician prior to closure was that claimant was not medically stationary. (Exs. 12 to 15).

Because claimant has finally prevailed after remand from the court, she is entitled to a carrier-paid attorney fee for her counsel's services before the Board and the court. See Cleo I. Beswick, 43 Van

Natta 1314 (1991). After considering the factors in OAR 438-15-010(4) and applying them to this case, we find that $2,500 is a reasonable assessed attorney fee for claimant's counsel's services on Board review and before the court, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case (as represented by claimant's appellate briefs before the Board and court), and the value of the interest involved.

IT IS SO ORDERED.

January 13, 1994 Cite as 46 Van Natta 56 (1994)

In the Matter of the Compensation of
ALBERT A. SCOTT, Claimant
WCB Case No. 92-15262
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of Referee Crumme's order that: (1) declined to award a penalty and related attorney fee for the SAIF Corporation's allegedly untimely payment of proceeds from a Claim Disposition Agreement (CDA); and (2) declined to award an assessed attorney fee. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Penalty

The Referee concluded that, because proceeds of a claim disposition agreement (CDA), were not "compensation," no penalty could be assessed for an untimely payment of the amounts due under the CDA. We disagree.

Subsequent to the Referee's order, we issued our decision in Scott Turo, 45 Van Natta 995 (1993). In Turo, we concluded that proceeds of a CDA constituted compensation and were recoverable as an actual claim cost from the claimant's third party settlement. In Turo, we reasoned that CDA proceeds were distinguishable from the proceeds of a disputed claim settlement (DCS) which disposed of a denied claim and provided proceeds in lieu of any compensation claimed by the claimant. We concluded that, to the contrary, a CDA involved an accepted claim and the proceeds were not "in lieu of" an injured worker's compensation. Rather, we found that the payment of CDA proceeds represented an advancement of benefits to claimant, "i.e., a 'lump sum' or 'accelerated' payment of compensation." Turo, supra at 999. Consequently, in Turo, we concluded that CDA proceeds constituted compensation within ORS Chapter 656. Also see Robert L. Hardt, 45 Van Natta 1487 (1993).

In the present case, we continue to adhere to our rationale as expressed in Turo, and we conclude that CDA proceeds are "compensation" as defined by ORS 656.005(8). Therefore, claimant is entitled to seek a penalty pursuant to ORS 656.262(10)(a), if he can establish that SAIF unreasonably delayed, resisted, or refused the payment of his CDA proceeds.

Here, the Referee found, and we agree, that the CDA proceeds were not timely paid. OAR 436-60-145(8) provides that, unless otherwise stated in the CDA, such proceeds shall be paid to claimant no later than the 14th day after the Board mails the agreement to the parties. However, the CDA executed by the parties did not provide for a different method of payment. Furthermore, the approved CDA was mailed to the parties in September 1992, yet SAIF did not pay the full amount of the CDA until December 1992. Finally, counsel for SAIF conceded that its adjustor had made an error in not paying out all of the CDA proceeds to claimant. SAIF's counsel noted that the CDA amounts were "ultimately" paid to claimant, but SAIF disputed that there was a basis for a penalty.

Under the circumstances, we conclude that SAIF's untimely payment of the CDA proceeds unreasonably delayed payment of those proceeds to claimant. Therefore, as we have found that CDA proceeds constitute "compensation," we assess a penalty pursuant to ORS 656.262(10). The penalty shall be based upon the CDA proceeds "then due" at the time SAIF untimely paid the remaining unpaid CDA proceeds. See Jeffrey D. Dennis, 43 Van Natta 857 (1993)(Delay period is the "then" with regard to the term "amounts then due"). Accordingly, we assess a penalty of 25 percent of that amount. One-half of the penalty shall be paid to claimant and one-half to his attorney in lieu of an attorney fee.

Assessed attorney fee

Claimant also contends that his attorney is entitled to an assessed attorney fee for services rendered in obtaining the remaining CDA proceeds. However, because we find claimant's asserted factual basis for an attorney fee under ORS 656.382(1) to be the same as the basis for the penalty we have awarded under ORS 656.262(10), claimant is not entitled to an additional attorney fee. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

ORDER

The Referee's order dated February 26, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that declined to award a penalty is reversed. The SAIF Corporation is assessed a penalty in the amount of 25 percent of the remaining balance of the CDA proceeds that SAIF untimely paid. The penalty is payable in equal shares to claimant and his attorney. The remainder of the Referee's order is affirmed.

Board Member Hall dissenting in part.

Although I agree with the majority's conclusion that SAIF's conduct in this case was unreasonable, I dissent for the following reason:

ORS 656.382(1) provides for an attorney fee if an insurer "refuses to pay compensation due under an order of a referee, board or court...". Here, the CDA constitutes a Board order, as 656.236(1) requires that such agreements must receive Board approval in the form of a final order. Consequently, because SAIF refused to pay compensation due under a Board order, an attorney fee award under 656.382(1) is appropriate. Therefore, I respectfully disagree with the majority's decision insofar as it awards a penalty, rather than an assessed attorney fee.

January 13, 1994 Cite as 46 Van Natta 57 (1994)

In the Matter of the Compensation of
DONNA J. WEST, Claimant
WCB Case No. 92-12473
ORDER ON REVIEW
Reeves, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

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

Board Member Gunn dissenting.

Dr. Grey, treating physician, opined that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome (CTS) condition. Thus, claimant has come forward with prima facie evidence of an occupational disease claim under ORS 656.802.

Dr. Rosenbaum provides the only contrary opinion. Rosenbaum examined claimant once and issued two reports. In the first, he opined that "Idiopathic carpal tunnel syndrome occurs most commonly in women in their 40's and 50's and there has been a suggestion that obesity is an additional risk factor for carpal tunnel syndrome condition." (Ex. 9). He could not exclude the possibility that claimant's work contributed to her condition, but concluded that work was not its major contributing cause. In his second report, Rosenbaum opined that claimant's CTS is ideopathic, because CTS is more common in middle aged women who are obese than in other persons. (Ex. 10). In addition, Rosenbaum reasoned that claimant only mopped 2 hours per day at work. (I note that claimant testified that she mopped 3-4 hours per day, almost twice as much as Rosenbaum reported.)

I would find Rosenbaum's opinion unpersuasive, because it is essentially general in nature, rather than specific to claimant. See Sherman v. Western Employers Insurance, 87 Or App 602, 605 (1987). Noting claimant's age, 56, and her weight, 167 pounds (characteristics which claimant shares with countless others), Rosenbaum placed claimant in "the highest risk group for developing idiopathic carpal tunnel syndrome." (Ex. 10-1). This reasoning suggests nothing more than risk, a "mere possibility" at best. See Gormley v. SAIF, 52 Or App 1055 (1981). Moreover, even assuming that Rosenbaum is correct that CTS afflicts people with certain characteristics more often than others, I don't see how that "evidence" defeats this claim.

This is not the first case touting the "popular" theory that a woman's CTS is not work-related (or even activity-related) if she is overweight and over 40. Typically, there is no evidence in the record supporting the theory. Because the foundation for the theory is absent, there is no factual or logical basis for evaluating the conclusions drawn from the theory. Thus, Rosenbaum's opinion lacks logical force. I do not find such unsupported "reasoning" persuasive and will not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

During my tenure at the Board, I have read many independent examiners' reports similar to this one. However, I have yet to find one where the general theory is supported by statistically significant evidence in the record. This type of medical opinion does not gain persuasiveness with repetition.

Under these circumstances and finding no persuasive reason to discount the opinion of claimant's treating physician, I would rely on it and conclude that this claim is compensable. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, I respectfully dissent.

In the Matter of the Compensation of
JODY L. WILLIAMS, Claimant
WCB Case No. 92-07615
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Herman's order that upheld the insurer's denial of claimant's low back condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that she injured her low back when she slipped and fell at work in November 1991. Although finding that such an incident occurred in November 1991, the Referee concluded that claimant failed to prove a causal relationship between the slip and fall and the low back condition. Claimant challenges this conclusion, contending that the medical evidence demonstrated that the November 1991 event caused her low back condition. We agree with claimant.

Claimant first sought treatment for low back pain in March 1992 from Dr. Cook, her family physician. Dr. Cook diagnosed lumbosacral strain. (Ex. 16). With regard to causation, Dr. Cook stated that there were no "chart notes indicative of back pain or injury for over two years prior to my 2 March 1992 entry, so I think it is only logical to assume that there was an event immediately preceding that visit which precipitated her current condition and need for treatment." (Id.)

Dr. Cook referred claimant to Dr. Lawton, orthopedic surgeon. Although Dr. Lawton did not provide an opinion regarding causation, his report recorded the history of the November 1991 slip and fall and gave a diagnosis of ligamentous injury to claimant's low back. (Ex. 9).

Finally, claimant sought treatment from Dr. Gifford, chiropractor, in November 1992. Dr. Gifford agreed with the diagnosis of lumbosacral sprain/strain. (Ex. 23-3). He also reported that "the major contributing cause of injury occurred in November of 1991 when [claimant] slipped and fell on-the-job, landing hard on her right buttock. Without treatment and continuing to work, she kept aggravating and worsening her low back until her acute onset of symptoms on March 2, 1992." (Id. at 4).

Based on Dr. Gifford's opinion, we find that claimant proved that the November 1991 event caused her low back condition. See Weiland v. SAIF, 86 Or App 810 (1983). Causation also is supported by Dr. Cook. There are no contrary opinions. Consequently, we conclude that claimant proved compensability. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

Claimant's attorney 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 claimant's attorney's 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 appellant's and reply briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 10, 1993 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing under the 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.

Board Member Haynes dissenting.

I agree with the Referee and the majority that claimant proved that she slipped and fell at work in November 1991. However, because I believe that the Referee properly concluded that claimant failed to show that the incident caused her current low back condition, I dissent.

The majority relies on the opinion of the treating physician, Dr. Gifford, who reported that the major contributing cause of claimant's lumbosacral sprain/strain was the November 1991 slip and fall. Normally, we defer to the treating doctor's opinion absent persuasive reasons to the contrary. Weiland v. SAIF, 86 Or App 810 (1983). In this case, I find compelling reasons against relying on Dr. Gifford's opinion.

First, it is important to note that claimant did not seek treatment from Dr. Gifford until November 1992, a year after the slip and fall. More importantly, his opinion relies on claimant's history that, after falling at work in November 1991, she developed back pain that was subsequently aggravated by work activities. That history, however, is only one of several versions that claimant provided to medical providers and in testimony at hearing.

Claimant first sought treatment for her low back from Dr. Cook, her family doctor, on March 2, 1992. His chartnote of that date stated that claimant had "fairly sudden onset of low back pain 4 days ago." (Ex. 1). A subsequent chartnote indicated that claimant and Dr. Cook "discussed the etiology of her pain and during her initial visit, it was really not documented if there was a specific insighting [sic] incident. She can't really tell me whether it occurred at work or not and we have agreed that it would probably be best pursued as a nonwork related claim in the absence of a specific causality at work." (Ex. 5).

After another visit, Dr. Cook noted that he and claimant again "discussed the probable etiology of [claimant's] pain and she really can't come up with a reason, other than her work activity that caused it. Based on her normal activity at home, I don't have an alternate explanation for her either and not withstanding [sic] my note of 3/20/92, I have no reason to question that this is a work related injury." (Ex. 12). This opinion is reflected in Dr. Cook's report, which indicated that, in view of the absence of any documented back injuries prior to March 2, 1992, it was "only logical to assume that there was an event immediately preceding that visit which precipitated her current condition and need for treatment." (Ex. 16).

Thus, the history obtained by Dr. Cook is completely at odds with that elicited by Dr. Gifford. Claimant did not even inform Dr. Cook of the November 1991 slip and fall, let alone attribute her back pain to the incident. Rather, Dr. Cook's chartnotes indicate that the onset of back pain was shortly before she sought treatment and that it was not accompanied by a specific event.

Additional evidence is consistent with the history obtained by Dr. Cook. On the 801 form, claimant provided "2-28-92" as the date of injury. (Ex. 6). On the medical history form for Dr. Gifford, claimant reported that she "first noticed" back symptoms on March 2. (Ex. 19B-3). In response to "how did it start", claimant wrote "fell 5 mth later couldn't walk" and "began to have massive pain 5 mth after fall." (Id.)

Dr. Lawton acquired yet another version of claimant's history. On April 8, 1992, Dr. Lawton noted that claimant fell "two to three months ago" and that she had increasing pain a month prior to the visit. (Ex. 9-1). Similarly, at hearing, claimant testified that "from January", she had occasional pains until, on February 28, "all of a sudden that day it just hurt so bad I couldn't handle it." (Tr. 34-35). Claimant also explained that she was "confused" because she believed the slip and fall occurred after December 24, 1991 but recognized that she was incorrect since an OSHA form showed that the event was in November 1991. (Id. at 47-49).

Thus, claimant's own testimony does not support the history relied upon by Dr. Gifford that her back pain began in November 1991 following the slip and fall. Due to the inconsistencies in this record regarding claimant's history, I am unable to conclude that Dr. Gifford's history is reliable and complete and, therefore, persuasive. The remaining opinion by Dr. Cook is based on the occurrence of an injurious event shortly before the initial treatment on March 2, 1992. Because such a theory was not asserted or proved by claimant, I also find Dr. Cook's opinion to be unpersuasive. Lacking medical proof of a causal relationship between the November 1991 slip and fall and her need for treatment in March 1992, I would conclude that claimant failed to prove compensability.

In the Matter of the Compensation of
GARY C. FISCHER, Claimant
WCB Case No. 91-08489
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Davis' order that: (1) declined to consider a "post-reconsideration proceeding" medical report from claimant's attending physician; and (2) affirmed an Order on Reconsideration which awarded 53 percent (53 degrees) scheduled permanent disability for a left eye injury. On review, the issues are evidence and extent of scheduled permanent disability.

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

Claimant sustained a left eye injury on September 21, 1989. A December 19, 1990 Determination Order closed the claim, finding claimant medically stationary on September 24, 1990 and awarding 53 percent (53 degrees) scheduled permanent disability. Claimant requested reconsideration, disagreeing with the rating of disability, but not objecting to the impairment findings by his attending physician. In his request for reconsideration, claimant claimed that he had sustained a partial loss of peripheral vision, a fixed pupil (photophobia), double vision, and that he needed a special bifocal eyeglass lens. A May 21, 1991 Order on Reconsideration affirmed the Determination Order in all respects.

Exhibit 14 is a September 26, 1991 letter from Dr. Rich, claimant's treating physician. Based on a September 9, 1991 examination, Dr. Rich reported greater loss of visual acuity than that described in his November 15, 1990 closing examination. He also reported, for the first time, that claimant had experienced loss of peripheral vision and of corneal density.

At hearing, claimant offered Exhibit 14. Relying on our decision in Gary C. Fischer, 44 Van Natta 1597, on recon 44 Van Natta 1655 (1992), the Referee excluded the exhibit. In Fischer, we held that a medical report from the attending physician, which was generated after the Order on Reconsideration, could not be considered pursuant to ORS 656.268(5). Id.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court considered the admissibility of documents at hearing in view of ORS 656.268(5). That statute limits the evidence that may be submitted at the reconsideration proceeding to that which corrects erroneous information and medical evidence that should have been submitted by the attending physician at the time of claim closure. Finding that ORS 656.283(7), which pertains to the presentation of evidence at hearing, contained no similar limitation, the court held that a Referee may consider evidence that could not have been submitted to the Director on reconsideration. Id.

We recently applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7); 656.283(7)) were applicable. Id.

Here, Exhibit 14 was not admitted by the Referee because it was not within the limitations imposed by ORS 656.268(5). However, pursuant to Smith and Luciani, Exhibit 14 cannot be excluded at hearing on this basis. Nonetheless, this conclusion does not resolve the issue of whether the exhibit is otherwise relevant and material evidence. While ORS 656.268(5) does not apply to evidence submitted at hearing, there are other statutory limitations concerning what evidence may be used in the evaluation of a worker's permanent disability.

ORS 656.268(7) is the only statutory limitation that directly speaks to admissibility of evidence. That provision requires the Director to refer the claim to a medical arbiter or panel of arbiters if the basis for objection to the notice of closure or determination order is a disagreement with the impairment used in rating a worker's impairment. The statute further provides that:

> "The findings of a medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis supplied).

Thus, where a medical arbiter or panel of arbiters has been appointed by the Director, ORS 656.268(7) operates to prohibit any subsequent medical evidence concerning a worker's impairment from being admitted into the record at hearing.[1] Here, no medical arbiter was appointed, and therefore, ORS 656.268(7) does not apply.

ORS 656.245(3)(b)(B) states that, "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." See Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). We have interpreted this provision to mean that with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning the worker's impairment. Dennis E. Connor, 43 Van Natta 2799 (1991). We have further held that impairment findings from a physician, other than the attending physician at the time of claim closure, may be used only if those findings are ratified by the attending physician. Alex J. Como, 44 Van Natta 221 (1992). See also OAR 436-10-080(5).

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[1] ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself. Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993).

Unlike ORS 656.268(7), ORS 656.245(3)(b)(B) does not affirmatively state that any medical evidence that does not fall within its limitations is not admissible. However, it does affirmatively identify who may make findings concerning the worker's impairment. Koitzsch, supra. Therefore, while the statute itself does not state that medical findings concerning a worker's impairment that are not within its limitations are inadmissible, it operates to essentially exclude such evidence from consideration when a worker's permanent impairment is evaluated. In other words, even if admissible under the Smith and Luciani rationale, such findings are not probative insofar as they pertain to substantive evidence regarding a worker's permanent impairment.

Inasmuch as Dr. Rich is claimant's attending physician, the limitation in ORS 656.245(3)(b)(B) is also not applicable.

The final limitation on evidence concerns when a worker's permanent impairment is evaluated. Under the current statutory scheme, the extent of a worker's permanent disability is evaluated by referees and the Board as of the time of the Reconsideration Order. ORS 656.283(7).[2]

Like ORS 656.245(3)(b)(B), ORS 656.283(7) does not affirmatively state that medical evidence concerning a worker's impairment not within its limitations is inadmissible. However, unlike ORS 656.245(3)(b)(B), ORS 656.283(7) does not operate to exclude such evidence. Rather, ORS 656.283(7) designates a point in time at which a worker's permanent disability is evaluated. Thus, while it does not provide a clear statutory limitation on medical evidence concerning a worker's permanent disability, it does affect the relevancy of evidence that does not address a worker's condition at the pivotal "rating date" (the date of the reconsideration order).

Based on the aforementioned reasoning, it is clear that medical evidence concerning a worker's condition that is generated or based on examinations up to and including the date of the reconsideration order are relevant and can be considered in accordance with ORS 656.283(7). It is equally clear that medical evidence that is generated after the date of the reconsideration order, but which addresses a worker's permanent impairment as of the date of the reconsideration order would also be relevant and material evidence under ORS 656.283(7). Scheller v. Holly House, 125 Or App 454 (1993)(Post-reconsideration order medical evidence admissible under ORS 656.283(7) where no medical arbiter was appointed pursuant to ORS 656.268(7)).

The difficult question arises when the proferred medical evidence is not only generated after the date of reconsideration order, but is based on an examination that took place after the date of the reconsideration order. Since this medical evidence is necessarily based upon the claimant's condition at a point in time that is after the reconsideration order, the evidence may not be relevant to the evaluation of a worker's permanent disability pursuant to ORS 656.283(7).

Whether or not the evidence is relevant depends on the facts and circumstances of the particular case. For instance, if the medical examination consisted of new tests that had not been performed and there has been no change in claimant's condition since the date of the reconsideration order, a medical report based on that examination would appear to have relevance under ORS 656.283(7) because it would pertain to the same unchanged condition that was in existence at the time of the Order on Reconsideration. In the final analysis, whether or not this type of medical evidence should be considered must be decided on a case-by-case basis. Moreover, it would depend on which party was the proponent of the extent of permanent disability issue; i.e., who had requested the hearing and/or was seeking a change from the Order on Reconsideration award.

In sum, assuming the limitations in ORS 656.245(3)(b)(B) and ORS 656.268(7) do not apply, we conclude that medical evidence which concerns a worker's permanent disability, regardless of when it is generated, can be considered pursuant to ORS 656.283(7) provided that it is relevant to claimant's

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[2] ORS 656.295(5) contains the same language as ORS 656.283(7) but applies to the Board's evaluation of permanent disability as opposed to a Referee's evaluation of permanent disability.

permanent disability as of the date of the reconsideration order.[3] Having established the relevant analysis, we now turn to the present case.

Exhibit 14 is a report from Dr. Rich, claimant's attending physician. It is based on an examination that occurred approximately 4 months after the date the Order on Reconsideration. The report states that Dr. Rich "reassessed [claimant's status] and performed additional tests." Some of the tests were the same as previously performed by Dr. Rich, while other tests had not been previously performed. Based on this reassessment, Dr. Rich concluded that claimant's permanent impairment was higher than he had previously reported. Although Dr. Rich characterized the examination as a reassessment, the report contains no evidence with regard to whether claimant's condition had or had not changed between the May 21, 1991 reconsideration order and the September 9, 1991 examination. The report also does not indicate that it is addressing claimant's condition as of the date of the reconsideration order. In fact, the report is phrased in a manner that suggests that claimant's condition is being evaluated based on this "post-reconsideration order" examination and assessment.

In light of such circumstances, we conclude that it is more likely than not that Dr. Rich's report is addressing claimant's condition as of a date subsequent to the date of the Order on Reconsideration. Alternatively, the report is, at best, ambiguous as whether it is considering claimant's condition at the date of the reconsideration order or after that date. Inasmuch as it is claimant's burden to establish the relevancy of the report, we agree with the Referee that it should not be considered.

ORDER

The Referee's order dated March 31, 1993 is affirmed.

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[3] Similar considerations apply when the issue is whether a claim was prematurely closed. Specifically, the claimant has the burden to prove that he was not medically stationary at closure. Berliner v. Weyerhauser Corp., 54 Or App 624 (1981). In determining whether that burden has been met, we examine medical evidence available at closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition after closure will not be considered. See Scheuning v. J.R. Simplot & Co., 84 OR App 622, 625, rev den 305 OR 590 (1987). To be relevant, the evidence must address claimant's condition at the time of closure. (Id.) See Andrea M. Gildea, 45 Van Natta (1993) (Post closure report not considered because it reported a worsening and it did not indicate when claimant's condition had worsened - pre or post closure).

In the Matter of the Compensation of
MARK D. FULLER, Claimant
Own Motion No. 91-0455M
OWN MOTION ORDER
Vick & Gutzler, Claimant Attorneys
Saif Legal Department, Defense Attorney

By letters dated November 19, 1993 and December 22, 1993, claimant's attorney requests that the Board "relinquish" its jurisdiction over claimant's claim and refer the claim to the Department of Insurance and Finance, Benefits Section, for claim closure and a Determination Order in light of claimant's current compensable psychological condition. We are without authority to grant claimant's request.

As background information, claimant sustained a compensable low back injury on December 7, 1979. His aggravation rights regarding that claim expired on November 13, 1985. Subsequent to claimant's injury, his claim was reopened and closed several times.

Claimant's claim was last reopened by an Own Motion Order dated August 22, 1991, as amended on September 12, 1991. On November 3, 1993, the Board received notification from SAIF that claimant continues to receive temporary disability benefits under our September 12, 1991 order. Thus, claimant's claim remains in open status and there is no indication that claimant's condition has become medically stationary.[1]

On May 15, 1992, SAIF issued a denial of claimant's psychiatric, stomach, thyroid, and liver conditions. Claimant requested a hearing regarding that denial. (WCB Case No. 92-07455). At the hearing, the parties stipulated that claimant's need for psychological treatment was a consequential condition and that ORS 656.005(7)(a)(A) applied requiring claimant to establish that the work injury was the major contributing cause of the consequential condition. By Opinion and Order dated November 16, 1992, Referee Thye found that the 1979 low back injury was the major contributing cause of claimant's psychiatric condition. Therefore, he set aside SAIF's May 15, 1992 denial except as to the denial of thyroid and liver conditions. That order was not appealed and has become final by operation of law. Thus, claimant's psychiatric condition is compensably related to the 1979 injury.

In his November 19, 1993 letter, claimant's attorney notes that claimant's compensable psychological condition was not considered in the earlier closures of his claim. Therefore, he requests that "the Board relinquish jurisdiction in this matter and remand it to the Department for appropriate closure in light of claimant's current compensable psychological condition." Claimant's attorney cites no authority for the Board to "relinquish" its jurisdiction over this own motion claim and we can find none. To the contrary, we find that case law does not support claimant's proposition that a consequential condition found compensable after the expiration of aggravation rights entitles him to a disability rating by the Department.

In this regard, we find the manner that aggravation claims for which the aggravation rights have not expired to be instructive. An aggravation has two components: causation and worsening. The first issue addressed is whether the claimant's current condition is compensable. If it is compensable, then a determination is made as to whether the claimant has established a compensable worsening under ORS 656.273. See Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993); see also Judy D. Fairchild, 45 Van Natta 421 (1993); Lareta C. Creasey, 43 Van Natta 1735 (1991).

In Marie M. Sax, 44 Van Natta 2152 (1992), the Board applied its holding in Bertha M. Gray, supra, to an aggravation claim that involved a consequential injury. In Sax, the Board first determined that the work injury was the major contributing cause of the claimant's consequential knee condition. After making that determination, the Board proceeded to determine whether claimant had proved an aggravation claim under ORS 656.273. Marie M. Sax, supra at 2353. Finding that the claimant had established a compensable aggravation claim, the Board set aside the insurer's denial and ordered it to process the claim in accordance with law. Id. at 2354.

In addition, prior to the 1990 amendments, although the lesser legal standard of material contributing cause applied, the same type of analysis was used in these types of cases in that causation or compensability was first determined, then a determination was made as to whether the claimant had established a worsened condition pursuant to ORS 656.273. Jerry P. Shults, 41 Van Natta 1948 (1989); Kenneth H. MacDonald, 39 Van Natta 1042 (1987). If both determinations were made in the claimant's favor, the carrier's denial was set aside and the aggravation claim was remanded to the carrier for processing in accordance with law. Id.

Here, the same reasoning applies. The consequential psychological condition, once found compensable, is treated as an aggravation. The only difference is that, here, claimant's aggravation rights have expired. Therefore, the "processing in accordance with law" is different.

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[1] We note that, even if we were able to remand claimant's claim to the Director for a possible award of additional permanent disability benefits, any such action would be premature because claimant's condition is apparently not yet medically stationary.

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) confers exclusive jurisdiction on the Board for "aggravation" claims filed after the five year period has expired. Inasmuch as the aggravation rights on the 1979 injury claim have expired, the Board has exclusive own motion jurisdiction over this claim. See Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988). The Board has no authority to "relinquish" its exclusive own motion jurisdiction and remand this claim to the Department.

Furthermore, effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in our own motion capacity. Independent Paper Stock v. Wincer, 100 Or App 625 (1990); Charles W. Roller, 44 Van Natta 1001 (1992). Once a claimant's claim is in own motion status, his or her only entitlement to future monetary compensation is restricted to time loss benefits under limited circumstances, although he or she is entitled to lifetime medical benefits related to the compensable injury. ORS 656.278(1)(a).

In addition to being without authority to relinquish our jurisdiction over this own motion claim and remand it to the Department for a possible award of additional permanent disability compensation, any such action would circumvent the legislature's explicit directive limiting a worker's future monetary compensation to time loss benefits once the worker's aggravation rights have expired and the claim is in own motion status. ORS 656.278(1)(a); Independent Paper Stock v. Wincer, supra.

Accordingly, for the above reasons, we are unable to grant claimant's request to remand his claim to the Department for a possible additional award of permanent disability benefits. Therefore, claimant's request is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. HITTLE, Claimant
WCB Case No. 92-15831
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of claimant's weight loss program claim. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in June 1992. Before and after the injury, claimant weighed approximately 350 pounds.

In September 1992, claimant's treating physician, Dr. Eric Smith, occupational medicine specialist, recommended a weight loss program. The insurer denied the request on the basis that the injury did not cause claimant's weight condition. The Referee upheld the denial, reasoning that claimant failed to show that his compensable condition was the major contributing cause of the need for the weight loss treatment.

In discussing the weight loss program, Dr. Smith has indicated that claimant's obesity is "complicating" his recovery from his low back injury and that weight loss is necessary in order for the low back condition to resolve. (Exs. 15, 18, 24, 26).

Drs. Watson, neurologist, and Peterson, orthopedist, conducted an independent medical examination. Their report stated that the June 1992 injury was, "up until recently, the major contributing cause of [claimant's] need for treatment, but it is not the cause of the need for weight loss." (Ex 23-5).

A second independent medical examination was performed by Dr. Anthony Smith, orthopedic surgeon. That report indicated that the injury "continues to be the major cause of his persistent back discomfort, although his morbid obesity is also a very important factor." (Ex. 27-5). It further stated, however, that claimant's "present complaints are due to a combination of his back strain and his pre-existing weight condition. It is difficult to apportion the complaints between the injury and his weight." (Id. at 5-6). Dr. Smith agreed with the prior panel that claimant's "weight is not related to his industrial problem." (Id. at 5).

The claim in this case concerns the compensability of medical services rather than a determination of an initial claim; specifically, claimant seeks compensation for a weight loss program as part of the treatment for his compensable low back condition. Medical services "for conditions resulting from the injury" are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993).

We agree with the Referee that, according to the medical evidence, there is no causal relationship between claimant's obesity and his compensable injury. However, as explained by the court in Van Blokland v Oregon Health Sciences University, 87 Or App 694, 697-98 (1987), when a weight loss program is intended to resolve the claimant's compensable condition and not simply help the claimant lose weight, it is compensable. In other words, a weight loss program is compensable if continuing obesity contributes to the disabling results of a compensable injury, as long as the compensable injury also is a material contributing cause of the need for treatment. Id. at 698.

We find that such reasoning is applicable to this case. According to Dr. Eric Smith, a weight loss program is necessary in order to treat the compensable low back condition. Dr. Anthony Smith explicitly indicated that claimant's low back injury and obesity were contributing to his need for treatment. Consequently, we conclude that the weight loss program is compensable medical treatment. See ORS 656.245; Van Blokland v. Oregon Health Sciences University, supra.

The insurer argues that compensability of the medical treatment should be analyzed under ORS 656.005(7)(a)(B) because there is evidence that the compensable injury has combined with claimant's obesity. Furthermore, the insurer contends that the weight loss program is not compensable because the record shows that claimant's obesity is the major contributing cause of his need for treatment.

We agree that the record supports the insurer's assertion that claimant's need for treatment is a result of a combination of his compensable injury and obesity. However, at most the record demonstrates that claimant's obesity is a contributing factor to his need for treatment; we do not find that a preponderance of evidence proves that the obesity was the major contributing cause. Therefore, assuming that ORS 656.005(7)(a)(B) is the appropriate statute to analyze the compensability of the medical services, we would continue to conclude that claimant proved the weight loss program to be compensable because we would find the injury to be the major contributing cause of claimant's need for the program.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer'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 claimant's attorney's services at hearing and on review is $2,750, 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 interest involved.

ORDER

The Referee's order dated April 1, 1993 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 $2,750, to be paid by the insurer.

In the Matter of the Compensation of
JIMMY L. HOLSAPPLE, Claimant
WCB Case No. 91-12291
ORDER ON REMAND (REMANDING)
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Holsapple v. Osborn, 123 Or App 630 (1993). The court has reversed our prior order, which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Reasoning that the Hearings Division had authority to consider a reconsideration order whether "invalid" or "valid," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A May 20, 1991 Notice of Closure closed claimant's injury claim with an award of 33 percent scheduled permanent disability for the left hand. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The August 29, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Notice of Closure in all respects. In addition, the Order on Reconsideration recognized that claimant was entitled to an examination by a medical arbiter and indicated that the Appellate Unit would schedule the claim for a medical arbiter review pursuant to ORS 656.268(7). (Ex. 12-1). Claimant requested a hearing.

The Referee found the Order on Reconsideration invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order.

In our prior order, we affirmed the Referee's order dismissing claimant's request for hearing for lack of jurisdiction. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

In Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court reversed the reasoning we used in deciding Olga I. Soto, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Here, relying on its decision in Pacheco-Gonzalez v. SAIF, supra, the court has remanded our prior order for reconsideration. Accordingly, we proceed with our reconsideration.

The parties in this case waived the opportunity to present testimony. Instead, the case was submitted to the Referee on the written record. No medical arbiter's report was included among the submitted exhibits.

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. ORS 656.295(5). Under the circumstances of this case, we find the record insufficiently developed. Moreover, in light of the Referee's rulings, we find a compelling reason to remand. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Betty S. Tee, 45 Van Natta 289 (1993). Consequently, we remand this matter to the Referee

for further evidence taking.[1] See Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993); Nancy M. Buckles, 45 Van Natta 2077 (1993).

Accordingly, the Referee's order dated December 9, 1991 is vacated. We remand to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall conduct further proceedings in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7). Once these further proceedings are completed, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

[1] The record is silent as to whether a medical arbiter examination has yet been performed and/or whether a medical arbiter report has been generated. Thus, the parties should make appropriate arrangements with the Director, if necessary. Thereafter, the assigned Referee should be contacted to continue with the proceedings. Linda M. Cross, 45 Van Natta 2130 (1993).

In the Matter of the Compensation of
JOSEPH S. HULL, Claimant
WCB Case No. 93-00151
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Hall and Westerband.

The SAIF Corporation requests review of Referee Podnar's order that awarded an attorney fee under ORS 656.386(1) when SAIF rescinded its "de facto" denial of claimant's claim for an osteomyelitis condition prior to a hearing. On review, the issue is attorney fees.

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

Claimant's claim for an osteomyelitis condition was in "de facto" denied status at the time of the hearing request. Claimant raised the compensability of the claim in that request. In addition, claimant's counsel's pre-hearing efforts resulted in acceptance of the claim. Thus, counsel was instrumental in obtaining compensation for claimant without a hearing. Under these circumstances, the Referee properly awarded an attorney fee for claimant's counsel's services at the hearing level under ORS 656.386(1). See Gloria Shelton, 44 Van Natta 2232 (1992).

Since attorney fees under ORS 656.386(1) do not constitute compensation, claimant is not entitled to an attorney fee for services on review for finally prevailing on the issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated April 15, 1993 is affirmed.

Board Member Westerband specially concurring.

I write separately to distill the essence of our holding.

The Referee found, and we agree, that SAIF denied compensability of claimant's claim for an osteomyelitis condition. The Referee also found, and we agree, that claimant's attorney was instrumental in securing SAIF's acceptance of the claim without a hearing. Therefore, claimant's attorney is entitled to an assessed fee under ORS 656.386(1). See SAIF v. Allen, 124 Or App 183 (1993).

In the Matter of the Compensation of
THOMAS R. LEE, Claimant
WCB Case Nos. 92-15814 & 93-02711
ORDER ON REVIEW (REMANDING)
Robert Philmon, Claimant Attorney
Moscato, et al., Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Norman Marshall, a noncomplying employer, requests review of that portion of Referee Menashe's order that dismissed his request for hearing concerning the SAIF Corporation's acceptance of claimant's low back injury claim on the basis that the hearing request was untimely. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

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

On August 24, 1992, the Workers' Compensation Division issued a Proposed and Final Order finding Norman Marshall to be a noncomplying employer. On that same date, the Division sent a letter to the SAIF Corporation advising SAIF that Marshall had been determined to be a noncomplying employer. The letter also asked SAIF to process claimant's injury claim. The bottom of the letter stated "cc: w/notice: Norman Allan Marshall."

By letter of October 30, 1992, SAIF notified Marshall that it was accepting claimant's claim. SAIF's letter further informed Marshall that if he objected to the claim, he must request a hearing with the Workers' Compensation Board within 90 days from the date the Department referred claimant's claim to SAIF. The letter also informed Marshall that if a hearing was not requested within the 90 day time period, he would lose his right to object to the claim.

On December 11, 1992, the Board received Marshall's request for hearing contesting SAIF's acceptance.

CONCLUSIONS OF LAW AND OPINION

The Referee found that Marshall had not timely requested a hearing concerning SAIF's acceptance of claimant's June 22, 1992 injury claim. Therefore, the Referee concluded that he did not have jurisdiction over Marshall's hearing request and dismissed it.

Prior to 1991, there was no statutory provision which required the Director to notify a noncomplying employer of a referral of a claim to SAIF for processing. Moreover, there was no statutory time limit in which a noncomplying employer could request a hearing concerning SAIF's acceptance of a claim. See Blain v. Owen, 106 Or App 285, rev den 312 Or 80 (1991).

However, in 1991, the Legislature amended ORS 656.054(1) to require the Director to notify a noncomplying employer of the referral to SAIF and of its right to object to the claim. In addition, the amended version of ORS 656.054(1) requires a noncomplying employer to request a hearing objecting to a claim within the 90-day time period set forth in ORS 656.262(6). Amended ORS 656.054(1) became effective September 29, 1991. See Oregon Laws 1991, Chapter 679, Section 1.

As amended, ORS 656.054(1) provides in relevant part:

> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. At the time of the referral of the claim the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim.

> . . . At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim." (Emphasis supplied).

ORS 656.262(6) provides that, "[w]ritten notice of acceptance or denial shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim." Thus, reading ORS 656.054(1) and ORS 656.262(6) together, a noncomplying employer has 90 days after the claim is referred to SAIF by the Director to request a hearing objecting to a claim.

Contrary to Marshall's assertion, at the time the claim was referred to SAIF, the Director's rules required the Workers' Compensation Division to notify the noncomplying employer of the referral of the claim to SAIF and its right to object to the claim within 90 days of the referral at the same time. See OAR 436-80-060(1)(b),(c),(d)(Temp. Rules WCD Admin. Order 8-1992, April 15, 1992).

While the 90 day time period begins running after the claim is referred to SAIF, ORS 656.054(1) requires the Director to notify the noncomplying employer of the referral of the claim to SAIF and notify the noncomplying employer of its right to object to the claim. Thus, the issue is one of due process: did Marshall receive notice from the Director?

While it appears that the Workers' Compensation Division may have complied with the notice requirements, we cannot reach that conclusion with any certainty on this record. Exhibit 77 indicates that the Division's referral letter was copied to Marshall with notice. However, it does not indicate what the "notice" consisted of, nor does it indicate that it was mailed to Marshall's correct address. Moreover, the record does not contain any evidence concerning whether or not Marshall received Exhibit 77 with or without the "notice."

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

Inasmuch as the resolution of the jurisdictional issue is dependent on whether the Director provided proper notice to Marshall, we conclude that the record has been incompletely developed. Accordingly, we vacate the Referee's order and remand this matter to the Referee with instructions to reopen the record for additional evidence consistent with this order. The Referee is further instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7). The Referee shall then issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated May 5, 1993 is vacated. The matter is remanded to Referee Menashe for further proceeding consistent with this order.

In the Matter of the Compensation of
ARTHUR MILLER, Claimant
WCB Case No. 92-10628
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of Referee Hoguet'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

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a service representative for the insured's employer. As early as January or February 1992, claimant's supervisor informed claimant of the employer's plans to "downsize" the work force and the possibility that claimant would be terminated. Claimant was given similar warnings on three or four other occasions. Each time, claimant got a reprieve, until the last time, when claimant was laid off in June 1992.

Claimant filed a claim under ORS 656.802(3). Specifically, claimant alleges that he developed a psychological condition as a result of the employer's "downsizing," and because the employer repeatedly warned him of his impending termination, but failed to terminate him until June 1992.

In order to prove a compensable mental condition, a claimant must show that the employment conditions producing the mental disorder are not "generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment." ORS 656.802(3)(b).

Here, claimant first sought treatment at a hospital several days before receiving notice of termination. He was diagnosed with "situational anxiety and insomnia." (Ex. 2). Claimant then sought treatment with Dr. Seeley, internist, who diagnosed "severe stress disorder related to [employer's] handling of his possible dismissal." (Ex. 3-1).

Following his receipt of the notice of termination, claimant's symptoms increased. (Ex. 6-6). He underwent an examination for the insurer conducted by Dr. Davies, clinical psychologist. Dr. Davies reported that claimant experienced an adjustment disorder with mixed emotional features during May, June, and July 1992. (Id. at 7). He also stated that the "source of stress was clearly the issues surrounding impending termination and eventual termination," adding that the employer's "communications may have been given to him in a less-than-optimal format, but it was the deeper issues associated with the 'stigma' and 'reality' of being rejected that triggered his emotional response." (Id. at 7-8).

Dr. Paltrow, psychiatrist, also examined claimant on one occasion. Dr. Paltrow diagnosed adjustment disorder with anxious mood, attributing the condition to "stressors on the job" and claimant's "working environment." (Ex. 7). Although the discussion contained in Dr. Paltrow's report shows that the job stressors related to claimant's termination, Dr. Paltrow does not specifically identify the particular working conditions that caused claimant's disorder.

The medical evidence shows that claimant's emotional condition was caused by the employer's warnings of impending termination and the actual discharge. However, a mental condition caused by cessation of employment is not compensable. ORS 656.802(3)(b); Kip S. Helm, 45 Van Natta 1539 (1993). Therefore, we do not consider claimant's termination in determining compensability.

With regard to the employer's warnings of termination, claimant argues that such a condition can support compensability because it relates to the "circumstance and manner of discharge" rather than the actual termination. In particular, claimant asserts that he was put on an "emotional rollercoaster" because the warnings were not carried out until June 1992, and that it was this effect, rather than the fear of discharge itself, that caused his mental disorder.

Even if we were to decide that the employer's warnings did not fall within ORS 656.802(3)(b) and could be considered in determining compensability, the medical evidence fails to show that this factor alone was the major contributing cause of claimant's mental disorder. As discussed above, Dr. Davies reported that both the impending termination and the discharge itself caused claimant's condition. Dr. Paltrow does not specify which particular factors caused claimant's emotional condition or discuss to what degree those factors caused claimant's condition. Therefore, we conclude that claimant did not prove that the warnings were the major contributing cause of his mental condition and that his claim fails on this basis.

The dissent relies on Elwood v. SAIF, 298 Or 429 (1985), where the court drew a distinction between a mental condition caused by the "stress of actual or anticipated unemployment," and an "illness resulting from the circumstances and manner of discharge," holding that the former was not compensable while the latter might be compensable. Inasmuch as the definition of a mental disorder was codified subsequent to Elwood, we question the holding's continuing vitality. Nevertheless, even if the Elwood rationale remains applicable, we disagree with the dissent's reasoning.

The dissent argues for a more narrow interpretation of what constitutes "anticipated unemployment." The dissent states that "anticipated unemployment" refers to a situation where an employee is told that his job will, in fact, be terminated at a certain future date, and the employee is, in fact, on that date, terminated.

We believe the dissent misses the point of the distinction drawn by the Elwood court, which said:

> "The line, we think, runs between illness resulting from the stress of actual or anticipated unemployment, which is not compensable, and illness resulting from the circumstances and manner of discharge, which can be regarded as events still intrinsic to the employment relationship before termination and can lead to compensation." (Emphasis added).

Elwood v. SAIF, 298 Or at 429.

Here, the weight of medical evidence shows that claimant's stress-related disorder resulted primarily from his anticipation of unemployment, and the "stigma" claimant attached to the loss of his job. The fact that claimant had more time, due to the advance warnings, to anticipate his unemployment, does not alter the fact that the root cause of his disorder was the anticipation of his unemployment. Moreover, these advance warnings are suggestive of employment conditions that are generally inherent in every working situation. See ORS 656.802(3)(b).

Finally, the direct relationship between the warnings given and claimant's anticipated and eventual unemployment is underscored by the Worker Adjustment and Retraining Notification Act (WARN), 29 USC 2101, et seq. WARN protects workers, their families and communities by requiring employers to provide notification at least 60 days in advance of plant closings and mass lay-offs. The purpose of requiring such advance notice is to "provide workers and their families some transition time to adjust to the prospective loss of employment, to seek and obtain alternative jobs, and, if necessary, to enter skill training or retraining that will allow these workers to successfully compete in the job market." 20 CFR Sec 639.1.

Even where WARN does not apply, for example, to an employer that has fewer than 100 employees, section 7 of WARN encourages all employers to comply with the notice provisions, stating that the non-covered employer should, "to the extent possible, provide notice to its employees about a proposal to close a plant or permanently reduce its work force." (Emphasis added). However, where the Act applies, at least 60 days advance notice must be given. "Therefore, an employer who is anticipating carrying out a plant closing or mass layoff is required to give notice to all affected employees." 29 CFR Sec. 639.4.

Here, the warnings given and the temporary reprieves related directly to the anticipation and eventual fact of claimant's unemployment. The only thing arguably "unusual" here is that claimant was given advance notice, and was fortunate to have temporary reprieves. Therefore, we disagree with the dissent's contention that the stress disorder concerned claimant's employment conditions as opposed to the cessation of his employment.

ORDER

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

Board Member Gunn dissenting.

The majority concludes that claimant's mental disorder is not compensable because it was caused by stress resulting from the actual or anticipated termination of his employment. I disagree and, therefore, dissent.

The employment conditions causing claimant's mental disorder began in August 1991, almost one year before his termination. At that time, claimant was advised that he might lose his job as a result of the employer's restructuring. However, he was not terminated at that time. Later, in January 1992, claimant was again advised that he might lose his job. Again, he was not terminated. On at least two more occasions, in May and June of 1992, claimant was told that he might possibly lose his job due to the employer's "downsizing."

Claimant, who was 51 years old at the time of hearing, did not believe that he would lose his job. He began working longer hours and accepting next-day assignments requiring travel. He joined a support group to cope with his anxiety about the possibility of losing his job. On June 26, 1992, he sought urgent care for anxiety and insomnia. He was diagnosed with situational anxiety. Three days later, he saw Dr. Seeley who diagnosed severe stress disorder "related to [the employer's] handling of [claimant's] possible dismissal." The next day, on June 30, 1992, claimant received the first notification that his job had been terminated.

Thus, claimant's mental disorder arose and required treatment before he was notified of his discharge from employment. The majority found, nonetheless, that the mental disorder resulted from the stress of "anticipated unemployment." In so finding, the majority misinterprets the Supreme Court's decision in Elwood v. SAIF, 298 Or 429 (1985). The Court held that a mental illness resulting from the stress of "actual or anticipated unemployment" is not compensable. Id. at 433. The Court did not define what it meant by "anticipated unemployment"; however, the Court's intended meaning is apparent from its discussion of an example "when an employee is told that her job will terminate six months in the future and in consequence worries herself into a mental illness." Id. at 432. Based on the Court's example, I would conclude that "anticipated unemployment" refers to a situation where an employee is told that his job will, in fact, be terminated at a certain, future date.

That is not the situation here. Claimant was not notified of his job termination and, therefore, did not "anticipate" his unemployment until June 30, 1992. By that time, claimant had already sought treatment for a stress disorder relating to the employer's handling of the "downsizing" and his possible termination. Even Dr. Davies, independent examining psychologist, was "thoroughly convinced" that claimant experienced an adjustment disorder in May and June 1992. (See Ex. 6-7). Inasmuch as claimant's mental disorder arose before his anticipated unemployment, the stress of anticipated or actual unemployment could not have played any role in the development of his disorder. Therefore, Elwood should not be applied to bar his claim. Rather, I view the employer's communications about "downsizing" to claimant prior to notification of his discharge as events more intrinsic to the employment relationship than his eventual discharge.

The majority asserts that the congressional enactment of the WARN Act supports an interpretation of the term "anticipated unemployment" to include notice of prospective mass layoffs. I disagree. Had the Oregon legislature or appellate courts endorsed the use of federal labor law to interpret an Oregon workers' compensation statute or court opinion, I might be persuaded by the majority's analysis. However, the term "anticipated unemployment" was created and applied by the

Supreme Court in Elwood; therefore, I look to the Court's decision to interpret its meaning. As stated above, the only evidence I could find of the Court's intended meaning is its example of an employee who is told that her job will terminate at a certain, future date. That was not the case here. The inquiry stops there; I would not expand the Court's holding to bar compensation under the facts of this case.

Finally, I disagree with the Referee's conclusion that claimant's disorder is attributable to employment conditions generally inherent in every working situation. While it may be true that the potential for employee layoffs is a condition common to all employments, the manner in which this employer communicated that potential to claimant is not. On four separate occasions during a period of almost one year, the employer advised claimant of the possible loss of his job. That had the obvious effect of placing claimant on an emotional "rollercoaster," eventually resulting in his need for treatment.

I am not criticizing the employer's judgment, nor am I assigning any fault. It may well be that the employer was only trying to give claimant as much advance notice as possible before termination. However, the combination of repeated "notices" of possible termination and the substantial delay preceding the actual termination are conditions that I do not believe are common to all employments. See Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). Because those conditions are the only stressful conditions which precipitated claimant's need for treatment in June 1992 (prior to notification of discharge), I would conclude that claimant's mental disorder is compensable.

In the Matter of the Compensation of
CATHERINE WASHBURN, Claimant
WCB Case No. TP-93012
THIRD PARTY DISTRIBUTION ORDER
Paulson & Baisch, Claimant Attorneys
Nancy J. Meserow, 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 from a third party settlement. ORS 656.593(3). We approve the settlement and find that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In June 1992, claimant sustained a compensable right wrist injury when she slipped and fell in the lobby of an office building. She sustained a non-displaced linear fracture of the scaphoid bone.

GAB Business Services (GAB), as claims administrator for claimant's employer, accepted the claim and began providing compensation. To date, its lien totals $8,931.09.

In July 1993, Dr. Tilson, claimant's attending physician, performed a closing evaluation. Noting claimant's ongoing complaints of stiffness, aching, and weakness, Dr. Tilson reported that such symptoms were consistent with a closed fracture. Determining that claimant's fracture had healed without objective residuals, Dr. Tilson concluded that claimant had suffered minimal subjective impairment.

Claimant, through her legal counsel, filed a cause of action against a third party (the owner of the office building). Claimant alleged that the third party had been negligent in its care of the building. In response, the third party contended that claimant had been contributorily negligent in failing to maintain proper control of herself as she moved through the building's lobby.

The third party insurer and claimant have agreed to settle the action for $10,000. If the settlement is approved, following the distribution of claimant's counsel's 1/3 attorney fee ($3,333.34), litigation expenses ($636.50) and claimant's statutory 1/3 share ($2,010.06), GAB would receive the remaining balance ($4,020.10).

GAB has declined to approve the settlement. Contending that claimant has not established why she would not prevail in her third party action, GAB asserts that the settlement is unreasonable because GAB will not receive full reimbursement for its entire lien.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $10,000 is reasonable. A distribution of settlement proceeds in accordance with ORS 656.593(1) is "just and proper."

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).

GAB objects to the settlement on the basis that claimant has failed to show why she would not prevail in her action against the third party. Yet, as noted above, the applicable standard is whether the proposed settlement is grossly unreasonable. Thus, it is not incumbent on claimant to establish whether she would prevail at trial. Rather, our review is confined to a determination of whether the proposed compromise of claimant's third party action is grossly unreasonable.

Furthermore, we have previously held that, as the prosecutor of her third party action, a claimant is aware of the potential weaknesses of her case, as well as the statutory distribution scheme and her lienholders. See Kathleen J. Steele, 45 Van Natta 21 (1993). Considering this accessibility to vital factual information and relevant statutory prerequisites, we have reasoned that the claimant is in the best position to make an informed and reasoned decision regarding the appropriateness of a settlement offer. Id. Moreover, with that knowledge, the claimant has the capacity to accurately calculate what her eventual net recovery will be, should she accept such an offer. Id.

Consequently, although there may be reasons to proceed with litigation, we conclude that claimant and her counsel are in the best position to weigh the risks of litigation versus the certainty of a settlement. See e.g. Karen A. King, 45 Van Natta 1548 (1993); John C. Lappen, supra (Paying agency's arguments that the claimant should have proceeded with litigation were not supported by the record, and in any event, costs attributable to further litigation would have been deducted from any third party recovery before the remainder would become subject to the paying agency's lien).

The fact that GAB would not recover full reimbursement of its entire lien is likewise not determinative. In the event that the $10,000 settlement is allocated in accordance with the statutory distributory scheme, GAB stands to recover $4,020.10, while its asserted lien amounts to $8,931.09. In other words, GAB would receive approximately 45 percent of its lien. We have previously held that full satisfaction of a paying agency's lien does not equate with a determination that a third party compromise is grossly unreasonable. See Denita I. Cleveland (Hall), 44 Van Natta 468 (1992); Jill R. Atchley, supra; John C. Lappen, supra (Settlement approved despite paying agency's recovery of 25 percent of its asserted lien).

Accordingly, after reviewing the parties' respective positions, as well as the record (particularly claimant's attending physician's conclusion that claimant suffered minimal subjective impairment and the third party's "contributory negligence" defenses), we do not find the settlement amount of $10,000 to be "grossly unreasonable." In fact, we conclude that the proposed settlement is reasonable. We, therefore, approve the settlement. ORS 656.587.

We proceed to a determination of a "just and proper" distribution of 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, 1001 (1982).

In accordance with ORS 656.593(1)(a), litigation costs and attorney fees shall be initially disbursed. Then, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Finding no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1), we conclude that such a distribution would be "just and proper." See ORS 656.593(3). Accordingly, claimant's counsel is directed to distribute the settlement proceeds in the following manner:

Settlement	$10,000.00
1/3 Attorney Fee	3,333.34
Subtotal	$ 6,666.66
Litigation Costs	- 636.50
Subtotal	$ 6,030.16
Claimant's 1/3 Share	- 2,010.06
Remaining Balance (GAB's Share)	$ 4,020.10

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH L. WITT, Claimant
WCB Case No. 88-07709
ORDER ON REMAND
Black, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. EBI Insurance Company v. Witt, 113 Or App 7 (1992). The Court has reversed the Board's order in Ralph L. Witt, 42 Van Natta 2628 (1990), that awarded claimant temporary partial disability (TPD) beyond a two-year period. The Board had concluded that claimant was entitled to the additional TPD under ORS 656.212, because there were two unconsecutive periods of temporary partial disability. Reasoning that the record did not support a conclusion that claimant's disability was "temporary in character," the court held that ORS 656.212 was not applicable. Consequently, the court remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our November 21, 1990 order.

CONCLUSION OF LAW AND OPINION

The Referee awarded TPD not to exceed a two-year period. In addition, the Referee declined to assess penalties and attorney fees for the insurer's failure to pay TPD beyond the two-year period.

On review, we awarded additional TPD. Ralph L. Witt, supra. The insurer was also assessed penalties and attorney fees for its failure to pay TPD in excess of the two-year period.

The court has reversed our order. EBI Insurance Company v. Witt, supra. Reasoning that the record does not support a conclusion that claimant's disability is "temporary in character," the court has concluded that ORS 656.212 is not applicable. Id.

In light of the court's holding, it follows that claimant is not entitled to TPD beyond the two-year period granted by the Referee's order. Since claimant is not entitled to additional TPD, it likewise follows that the insurer's failure to make such additional payments was not unreasonable.

Accordingly, on reconsideration of our November 21, 1990 order, we affirm the Referee's May 10, 1989 order, as reconsidered August 10, 1989.

IT IS SO ORDERED.

Board Members Gunn and Hall dissenting.

We disagree with the majority's reasoning that the court's holding has precluded a finding that claimant is entitled to additional temporary disability benefits. Consequently, we respectfully dissent.

In remanding, the court expressly determined that neither the referee nor the Board had decided whether claimant's disability is "temporary in character." See ORS 656.212. However, rather than leaving resolution of that question to the fact-finder on remand, the court proceeded to perform its own fact finding. Specifically, reasoning that the record did not support a conclusion that claimant's disability is "temporary in character," the court held that ORS 656.212 was not applicable.

We submit that such fact finding is strictly within the province of this Board, not the court. See ORS 183.482(7), (8); 656.298(6). Notwithstanding our reservations, since the court sits as a higher appellate forum, we are bound to follow its conclusion. Nevertheless, our adherence to the court's "temporary partial disability" holding does not lead us to the majority's conclusion.

It is uncontested that claimant was not able to return to his regular work activities. It is likewise undisputed that his compensable condition was not medically stationary. Under such circumstances, the claim could not be closed and the insurer was not authorized to terminate claimant's temporary disability compensation. See former ORS 656.268(1). Moreover, despite the insurer's acknowledgment that claimant has sustained permanent impairment, since claim closure can not be authorized at this point, no permanent disability award can be lawfully awarded.

Thus, by reasoning that the court's holding that ORS 656.212 precludes further temporary disability, the majority has essentially authorized the termination of temporary disability benefits. Inasmuch as the termination of such benefits in a claim like claimant's would be in clear violation of former ORS 656.268(1), we cannot agree with such a conclusion.

Because the court has held that ORS 656.212 is not applicable, claimant is not entitled to temporary partial disability benefits. However, since the claim remains open and claimant has neither returned or been released to regular work nor has his condition become medically stationary, the insurer is obligated to pay temporary total disability compensation. See former ORS 656.268(1).

Such a result would be consistent with both of the aforementioned statutory mandates. Moreover, this analysis would permit a "non-medically stationary" claimant to receive temporary disability benefits while he remained unable to return to his regular work.

The majority's holding would reach just the opposite result; i.e., preclude a "non-medically stationary" claimant who has been unable to return to regular work from receiving further temporary disability. In essence, claimant would be essentially left in "no-man's land." That is, unable to receive temporary disability compensation despite his undisputed inability to return to regular work, while also statutorily precluded from recovering a permanent disability award for his acknowledged permanent impairment because claim closure would be inappropriate since his compensable condition has not become medically stationary.

Finally, any potential overpayment of temporary disability benefits resulting from my proposed method would be ultimately offset against future permanent disability awards. As noted in the court's opinion, the insurer has acknowledged that claimant has suffered some permanent impairment. Thus, it would appear likely that the insurer could eventually recover any overpayment should it subsequently be determined on claim closure that one exists.

Accordingly, we would hold that claimant is entitled to temporary total disability for the period beyond his two-year period of temporary partial disability. In addition, we would adhere to the reasoning expressed in the Board's prior order concerning penalty and attorney fee issues regarding the insurer's claim processing.

In the Matter of the Compensation of
PEDRO M. FLORES, SR., Claimant
WCB Case No. 92-09021
SECOND ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

On January 12, 1994, we issued our Order on Reconsideration which, with supplementation, adhered to and republished our December 16, 1993 Order on Review that affirmed and adopted the Referee's order upholding the SAIF Corporation's denial of claimant's head and right shoulder injury claim. It has subsequently come to our attention that a copy of January 12 order was not mailed to claimant's counsel. Inasmuch as attorneys are not "parties" to these proceedings, we ordinarily would not republish an order on this basis. In this case, however, claimant did not retain counsel until after Board review was requested and the briefing schedule had expired. Claimant's newly retained counsel then requested postponement of the briefing schedule. We received the postponement request after issuance of our December 16, 1993 order and, therefore, treated the request as a motion for reconsideration. Given these special circumstances, we believe it is appropriate to republish our prior order, with a copy mailed to claimant's counsel.

Accordingly, we withdraw our January 12, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our January 12, 1994 order in its entirety. 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
WILLIAM L. HALBROOK, Claimant
Own Motion No. 93-0700M
OWN MOTION ORDER
Welch, et al., Claimant Attorneys

The insurer has submitted claimant's request for temporary disability compensation for his compensable right hand injury. Claimant's aggravation rights expired on February 22, 1993. The insurer recommends that the Board reopen claimant's claim. However, the insurer contends that time loss payments should be prorated because claimant is currently disabled from a subsequent work injury to his low back. In the alternative, the insurer argues that, because claimant is currently disabled due to a subsequent compensable low back injury, he was not in the work force at the time of the disability relating to his compensable right hand injury.

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 an October 20, 1993 letter, Dr. Layman, claimant's treating physician, requested authorization "to perform amputation [of the] right ring finger" on claimant. Thus, we conclude that as of October 20, 1993, claimant's compensable condition worsened requiring surgery, which is the time of disability.

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).

In a November 24, 1993 letter, the insurer acknowledges that claimant is currently disabled from a subsequent injury to his low back. Although the insurer notes that the issue of which employer is responsible for that subsequent low back injury is presently in litigation, it acknowledges that claimant is entitled to time loss benefits regarding that low back injury. Thus, the insurer concedes that claimant was in the work force at the time of his disability due to the low back injury.

In addition, at the time Dr. Layman recommended surgery regarding claimant's compensable hand injury, he stated that claimant felt that he needed to have his right ring finger removed or he would "be unable to continue doing the type of work he is doing at the present time." (Chart note dated September 29, 1993).

On this record, we find that claimant was in the work force at the time of the disability relating to his compensable right hand injury. First, the insurer concedes that claimant was in the work force at the time of his disability relating to his subsequent compensable low back injury and that he is entitled to time loss as a result of that injury. While claimant is receiving time loss due to a compensable injury, he remains in the work force in that, by definition, he is unable to work due to a compensable injury. Dawkins v. Pacific Motor Trucking, supra. Second, Dr. Layman's statements support a finding that claimant was in the work force at the time of disability and was willing to work. Thus, we reject the insurer's alternative argument that claimant was not in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's right hand injury claim to provide temporary disability compensation beginning the date of his surgery. When claimant's condition becomes medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

However, an injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, the insurer may petition the Benefits Section of the Workers' Compensation Division for a pro rata distribution of payments. OAR 436-60-020(7) and (8).

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.

In the Matter of the Compensation of
BONNIE OZMENT, Claimant
Own Motion No. 93-0767M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable back injury. Claimant's aggravation rights expired on October 15, 1986. 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.

Claimant underwent surgery for removal of the S1 screw on the left side of her back and to explore the fusion on November 5, 1993. Thus, we conclude that as of November 5, 1993, claimant's compensable condition had worsened requiring surgery, which is the time of disability.

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).

SAIF recommends against reopening of the claim for payment of temporary disability benefits on the ground that claimant was not in the work force at the time of disability. At the time of disability, claimant was serving as a foster parent. However, foster parenting is not wage-earning employment, as the payments do not represent compensation for services rendered by claimant under a contract of hire, but, rather, they are maintenance payments provided solely for the care and support of the foster child. Audrey L. Yakes, 42 Van Natta 187 (1990); ORS 656.005(27).

In a November 23, 1993 letter, Dr. Flanagan, claimant's treating physician, opined that claimant "would not have been able to be employed in any capacity available to her on a reasonably continuous basis because of the severity of her lumbar disc disease and chronic low back pain." In the November 23, 1993 letter, Dr. Flanagan also noted that, prior to serving as a foster parent, claimant ran her own used clothing store, which, he felt at the time, was the best option for her. However, Dr. Flanagan stated that "over a period of time it became obvious that even this level work was too much for her," and he then supported claimant's decision to close her store. Dr. Flanagan opines that the "work" claimant is doing currently as a foster parent, "is the only work available to her that she is reasonably capable of doing on a reasonably continuous basis. At times, even this work overtaxes her resulting in increased pain level."

In a letter dated November 19, 1993, claimant stated that she understood that foster parenting was not considered employment, but prior to serving as a foster parent, she was self-employed for approximately three years. She also stated that "my back kept me from being employable, but I found something I'm very proud of doing."

The Board concludes that, even though foster parenting cannot be considered wage-earning employment, claimant's efforts to serve as a foster parent demonstrate her willingness to work. Furthermore, Dr. Flanagan's opinion establishes that the work related injury made futile any reasonable efforts to seek work.

Inasmuch as claimant has submitted evidence that she was willing to work but not able to work because the compensable injury made such efforts futile, we conclude that she remained in the work force at the time of disability. Dawkins v. Pacific Motor Trucking, supra.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning November 5, 1993, the date she was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

January 18, 1994 Cite as 46 Van Natta 81 (1994)

In the Matter of the Compensation of
ROBERT L. SCHAUSS, Claimant
Own Motion No. 93-0644M
OWN MOTION ORDER ON RECONSIDERATION
Douglas Minson, Claimant Attorney

Claimant requested reconsideration of our October 29, 1993 Own Motion Order in which we declined to reopen his claim for own motion relief on the ground that he had not established he was in the work force at the time of his disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our October 29, 1993 order and granted the insurer an opportunity to respond to the motion. No response has been received from the insurer. After further consideration, we issue the following order in place of our October 29, 1993 order.

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

On July 29, 1993, Dr. Berkeley, treating neurosurgeon, requested authorization to perform L4-5 microdecompression and microdiscectomy on claimant's low back. Thus, we conclude that, as of July 29, 1993, claimant's compensable condition worsened requiring surgery, which is the time of disability.

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). Here, claimant must prove that he was in the work force on July 29, 1993, when his compensable condition worsened requiring surgery. 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).

In our October 29, 1993 order, the Board determined that Dr. Berkeley's statements in a July 14, 1993 chart note that claimant "did not work but was taking care of his children," provided evidence that claimant was not in the work force at the time of disability. However, in a November 15, 1993 letter, Dr. Berkeley stated that his July 14, 1993 statement "did not imply that [claimant] was intentionally keeping himself off work." Dr. Berkeley also stated in the letter that claimant "was not working when I saw him on July 14, 1993, because he could not find work, though he had repeatedly applied for various jobs."

In our October 29, 1993 order, the Board also considered a list of employers submitted by claimant, to whom he had sent his resume "since July 1991." Claimant did not supply dates on which he allegedly applied to the various employers on the list. With his request for reconsideration, claimant supplied the same list, but with dates of application for employment. On this list, he submits the names of four firms to whom he applied for employment from January 1993 through April 1993. In a November 8, 1993 letter, Mr. Murphy, owner of Pet Circus, stated that claimant applied for employment at his business during March 1993. Mr. Murphy stated that "during the month of May 1993, we also discussed the possibility of [claimant] buying my business. Unfortunately, we had already received an offer from another party."

In a November 12, 1993 letter from Northwest Appliance Parts, the writer stated that on about April 10, 1993, claimant "asked if I needed any help either full time or part time. I have not needed any help in the past few months."

On this record, we conclude claimant was willing to work and making reasonable efforts to find work when his compensable condition worsened requiring surgery. In addition, the insurer has not responded to claimant's evidence submitted on reconsideration that he was a member of the work force at the time of disability, and his contentions are, therefore, unrebutted.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he is hospitalized for treatment. When claimant is medically stationary, the insurer 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 the insurer 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
BRIAN G. VOGEL, Claimant
WCB Case No. 91-12115
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Pamela A. Schultz, Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Tenenbaum's order which dismissed, for lack of jurisdiction, his request for hearing concerning an Order on Reconsideration that awarded no permanent disability benefits for a right wrist injury. On review, the issues are jurisdiction and extent of scheduled permanent disability. We reinstate claimant's hearing request and award permanent disability.

FINDINGS OF FACT

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

Claimant's right wrist injury claim was closed by Notice of Closure on July 9, 1991, with no permanent disability award. Claimant requested reconsideration, specifically contesting the impairment findings of his attending physician, Dr. Hanley. On August 29, 1991, the Department issued its Order on Reconsideration affirming the Notice of Closure. In its order, the Department explained that it was affirming the Notice of Closure because it could not complete its reconsideration within the statutory time limit. The Department added that, because claimant challenged his attending physician's impairment findings, a medical arbiter would be appointed to examine his condition, and the report of that examination would be available for consideration at any subsequent hearing.

Claimant requested a hearing in September 1991. On December 11, 1991, while the hearing request was pending, claimant was referred to and examined by a medical arbiter, Dr. Gritzka. That same day, Dr. Gritzka issued a report of his examination findings. Claimant submitted that report to the Referee and it was admitted into evidence at hearing.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that, because no medical arbiter was appointed prior to the issuance of the Order on Reconsideration, the order was invalid, and the Hearings Division lacks jurisdiction to rate claimant's permanent disability. In so concluding, the Referee relied on our holding in Olga I. Soto, 44 Van Natta 697 (1992).

Subsequent to the Referee's order, however, the Court of Appeals reversed the reasoning we used in deciding Olga I. Soto, supra. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" Order on Reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Hence, the Referee had jurisdiction to review the Order on Reconsideration in this case. Further, inasmuch as the medical arbiter's report was available to the Referee at hearing, the Referee had the authority to consider the report in rating claimant's permanent disability. Therefore, we proceed to the extent issue.

Extent

Although the Referee dismissed claimant's hearing request, she also made alternative findings and conclusions regarding the merits of the extent issue, in the event her dismissal order was reversed on appeal. The Referee found that claimant has 5 percent impairment due to losses of range of motion and 37 percent impairment for losses of grip/wrist strength, supporting a total award of 40 percent scheduled permanent disability for loss of use or function of the right forearm. The parties do not dispute the Referee's finding that claimant has 5 percent permanent impairment due to losses of range of motion.

The parties dispute claimant's entitlement to a permanent disability award based on losses of grip/wrist strength. Specifically, the insurer contends that the Referee went outside the standards to find ratable losses of strength. We agree.

The applicable standards provide that "[d]isability is rated on the permanent loss of use or function of a body part due to an on-the-job injury. These losses, as defined and used in these standards, shall be the sole criteria for the rating of permanent disability in the scheduled body parts under these rules." Former OAR 436-35-010(2) (WCD Admin. Order 2-1991). The standards provide a rating for loss of strength in the upper extremities when the cause is a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit. Former OAR 436-35-110(2)(a). The rating allowed depends on which nerve is affected or impaired. Id.

There is no medical evidence that claimant's losses of grip or wrist strength are due to a peripheral nerve injury, loss of muscle or disruption of a musculotendonous unit. Contrary to claimant's assertion on review, a diagnosis of tendonitis does not, in and of itself, establish a disruption of the musculotendonous unit. Rather, "tendonitis" is merely an inflammation of tendons and of tendon-muscle attachments. Dorland's Illustrated Medical Dictionary 1315 (26th ed. 1981). "Disruption," on the other hand, means an abnormal separation. Id. at 397. Absent evidence that claimant suffered a tendon separation, we do not find that claimant's losses of grip or wrist strength are ratable under former OAR 436-35-110(2)(a). Inasmuch as claimant's strength losses are not ratable under the standards, he does not qualify for an award for those losses. See former OAR 436-35-010(2).

Accordingly, we conclude that claimant is entitled to no more than 5 percent scheduled permanent disability due to losses of range of motion.

ORDER

The Referee's order dated May 19, 1992 is reversed. Claimant's hearing request is reinsated. The Order on Reconsideration is modified to award claimant 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of the right forearm. Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
RICHARD A. WRIGHT, Claimant
Own Motion No. 93-0757M
OWN MOTION ORDER
Robert J. Guarrasi, Claimant Attorney
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 July 16, 1990. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

As a preliminary matter, we note that claimant's attorney appears to attempt to raise the issue of premature closure in his December 15, 1993 letter. Claimant's claim was last closed by Notice of Closure on February 18, 1993. Claimant did not appeal that Notice of Closure and it has become final by operation of law. Therefore, claimant cannot now raise the issue of premature closure in regard to his last claim closure.

Regarding the current request to reopen claimant's claim, 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 a July 2, 1993 chart note, Dr. Maxwell, treating physician, stated that claimant would probably benefit from having his low back stabilized at that time. Dr. Maxwell also stated that he "discussed with [claimant] instrumentation and re-fusion from L5 to the sacrum." In addition, by letters dated September 27, 1993 and October 21, 1993, Dr. Maxwell repeated his opinion that claimant's low back condition required surgery. Therefore, we conclude that, as of July 2, 1993, claimant's condition had worsened requiring surgery, which is the time of disability.

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 making reasonable efforts to find work; or (3) not working but willing to work, but 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 proving that he was in the work force at the time of disability.

In a letter dated November 24, 1993, claimant's attorney stated that claimant "was ready, willing, and able to receive, explore, and obtain appropriate employment activities. [Claimant], however, upon recommendation from his doctor and upon his own assessment of his personal functional capabilities, felt there was no work within his training and past experience he would be able to perform." In a letter dated December 15, 1993, claimant's attorney stated that claimant had reiterated to him that "while [claimant] was very interested in seeking and obtaining work, his physical condition was such that he could not, in good faith and good conscience, even approach potential employers because of his serious limitations" from the work injury.

Thus, claimant contends that he remained in the work force because he was willing to work but unable to work or make reasonable efforts to find work because of the work injury. Dawkins, supra. However, although stating that he felt incapable of working upon the recommendation of his physician, the record contains no evidence from claimant's physician regarding claimant's ability to work. Under the law, the relevant question is whether claimant was in the work force at the time of disability. Here, claimant has only established that he was unable to work after his low back condition worsened.

It is claimant's burden to prove that he remained in the work force and, other than the statements by his attorney, claimant offers no evidence to meet his burden of proof. In short, claimant must offer more than the bare assertions of legal counsel.

On this record, claimant has failed to prove that he was in the work force at the time of disability. 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.

In the Matter of the Compensation of
LAURA A. BOUSE, Claimant
WCB Case No. 93-00135
ORDER ON REVIEW
Jolles, Sokol, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of that portion of Referee Bethlahmy's order which upheld the SAIF Corporation's denial of claimant's jaw injury claim. On review, the issue is whether claimant's injury occurred within the course and scope of her employment.

We affirm and adopt the order of the Referee.

ORDER

The Referee's order dated April 23, 1993 is affirmed.

Board Member Hall dissenting.

Unlike the majority, I would set aside the SAIF Corporation's denial of the injury that claimant sustained as a result of her employer's wife's assault.

The record clearly documents that the employer had business and marital problems. As a result, the employer insinuated himself into claimant's life. The employer's wife suspected that he and claimant were having an affair, although this was not true. This is not a case where the employee brought the risk of assault to the work place and where the assailant, in this instance the employer's wife, was on the premises only because claimant happened to be present. See Robinson v. Felts, 23 Or App 126 (1975) (employee's murder not compensable when it was the result of a troubled personal relationship with the assailant and it was only by chance that the murder occurred at her place of employment).

In this case, the employer brought his personal problems to the job, and, consequently, the employer also brought an increased risk of assault to claimant to the job. Unlike the murder in Robinson, the assault on claimant at work occurred as a result of an increased risk of assault for which the employer was directly responsible. I would find that there was a sufficient relationship between the assault and a risk connected with claimant's employment to conclude that claimant's injury was compensable. See Barkley v. Corrections Div., 111 Or App 48, 53 (1993).

For these reasons, I dissent.

In the Matter of the Compensation of
ROBERT D. SLOAN, Claimant
WCB Case No. 92-09589
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Referee Livesley's order that set aside its denial of claimant's aggravation claim for a left knee condition. The insurer also contends that the Referee erred in admitting as rebuttal evidence a post-hearing report from claimant's attending physician. Claimant moves to strike the insurer's reply brief on the ground that it raises a new defense theory. On review, the issues are motion to strike, evidence and compensability. We deny the motion to strike and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

The hearing in this matter convened on October 15, 1992. A week before the hearing, on October 8, 1992, the insurer's counsel submitted to the Referee Dr. Kruse's written concurrence to a letter drafted by the insurer's counsel. (Ex. 16). On October 14, 1992, the day before hearing, the insurer's counsel submitted to the Referee Dr. Woolpert's written concurrence to a letter drafted by the insurer's counsel. (Ex. 17).

At hearing, the Referee admitted Exhibits 16 and 17 into evidence and granted, over the insurer's objection, claimant's motion to continue the hearing for the submission of a rebuttal report from claimant's attending physician, Dr. Potter. On December 8, 1992, at claimant's counsel's request, Dr. Potter wrote a letter responding to Exhibits 16 and 17. That letter was offered and admitted into evidence as Exhibit 19. The record was subsequently closed on January 27, 1993.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion, with the following supplementation.

Motion to Strike

Claimant argues that the insurer improperly raised, for the first time in its reply brief, a contention that claimant's current left knee condition constitutes a "combination condition" for which claimant must satisfy the "major contributing cause" standard under ORS 656.005(7)(a)(B). However, given our finding below that claimant has established compensability under the "major contributing cause" standard, we conclude that claimant has not been prejudiced by the insurer's action. Accordingly, claimant's motion is denied.

Evidence

The insurer argues that the Referee erred in continuing the hearing to admit Exhibit 19 as rebuttal evidence, rather than limiting claimant to cross-examination of Drs. Kruse and Woolpert concerning their opinions in Exhibits 16 and 17. We disagree.

OAR 438-07-023 provides that "[t]he party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on the issue." Furthermore, OAR 438-06-091(3) provides, in pertinent part, that a referee may continue a hearing for further proceedings "[u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence."

Here, inasmuch as claimant has the burden of proving the compensability of his aggravation claim, he had the right of "last presentation of evidence" on the aggravation issue. See OAR 438-07-023. Because the insurer submitted Exhibits 16 and 17 within a week before the hearing, we are persuaded that claimant could not, with due diligence, present the final medical evidence at hearing. Under these circumstances, we conclude that the Referee did not abuse his discretion in continuing the hearing to allow claimant to present the final rebuttal evidence from Dr. Potter. See OAR 438-06-091(3); James D. Brusseau II, 43 Van Natta 541 (1991).

We reject the insurer's argument that the Board rules limit claimant to a right of cross-examination of the authors of the insurer's medical reports. OAR 438-07-005(3), the rule cited by the insurer, contains no such limitation; it merely provides that a claimant has the right to cross-examine any medical expert who authors a report offered by the insurer.

We also reject the insurer's argument that claimant was allowed to present two rebuttal reports from Dr. Potter. Contrary to the insurer's assertion, Dr. Potter's October 14, 1992 report (Ex. 18) was not written in rebuttal to Exhibits 16 and 17. Exhibit 18 was solicited by claimant's counsel prior to his receipt of Exhibits 16 and 17; therefore, Exhibit 18 could not have been written as rebuttal evidence. Rather, Exhibit 19 was the sole rebuttal evidence presented by claimant.

Compensability

The Referee concluded that claimant had established that his current left knee condition is compensably related to his 1990 industrial injury. In so concluding, the Referee applied a "material contributing cause" standard. On review, the insurer argues that the current left knee condition is a combination of a preexisting degenerative condition and the industrial injury. The insurer contends, therefore, that claimant has the burden of proving that his industrial injury is the major contributing cause of his current left knee condition. See ORS 656.005(7)(a)(B).

Even if we agreed with the insurer's contention, we would still conclude that claimant has sustained his burden of proof. In this regard, we adopt the Referee's analysis of the medical evidence and his conclusion that Dr. Potter's opinion is the most persuasive medical evidence in the record. Based on Dr. Potter's opinion, (see Exs. 15, 18, 19), we find that the 1990 industrial injury is the major contributing cause of claimant's current left knee condition. Accordingly, the left knee 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 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 and statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 25, 1993 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
THOMAS L. CANSLER, Claimant
WCB Case No. 92-04592
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Hall.

Claimant requests review of Referee Mills' order that upheld the SAIF Corporation's denial of claimant's right knee injury claim. On review, the issue is compensability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated March 25, 1993 is affirmed.

Board Member Hall dissenting.

The majority concludes, as did the Referee, that claimant failed to carry his burden of proving that he sustained a compensable right knee injury as a result of a 20-foot fall. I dissent.

Although the contemporaneous medical records document an injury to claimant's left knee, the issue of whether the left knee was injured is not relevant to the present case. Regardless of whether the left knee was or was not injured, whether it was or was not properly x-rayed, or whether claimant originally complained only of left extremity injuries, the core issue now is whether the medical evidence links claimant's 20-foot fall to the torn meniscus in his right knee. The most persuasive medical evidence clearly makes the causal connection.

There is only one medical opinion that directly addresses the causation issue. Claimant's treating physician, Dr. Hanley, concluded that claimant injured his right knee as a result of the fall. The medical history upon which Dr. Hanley bases his opinion is undisputed. Claimant had no prior right knee problems, he fell 18-20 feet and there is no evidence of subsequent injuries to or causes of his right knee condition. It is this uncontradicted history that led Dr. Hanley to link claimant's right knee condition to his fall.

I would rely on Dr. Hanley's medical opinion and find that claimant carried his burden of proving a compensable right knee injury. For this reason, I dissent.

In the Matter of the Compensation of
FIONA E. DADY, Claimant
WCB Case No. 91-13044
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband, Gunn, and Haynes.

The self-insured employer requests review of Referee Neal's order that set aside its denial of claimant's chronic back pain condition. On review, the issue is compensability.

We affirm and adopt the Referee's order.

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 issues, and the value of the interest involved.

ORDER

The Referee's order dated April 29, 1993 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $750, to be paid by the self-insured employer.

Board Member Haynes dissenting.

Because I find that claimant has failed to meet her burden of proving legal causation, I respectfully dissent.

A "compensable injury" is an accidental injury "arising out of and in the course of employment requiring medical services or resulting in disability[.]" ORS 656.005(7)(a). To establish a compensable injury, claimant must show that: (1) she injured herself in performing her job; and (2) the injury sustained was a material contributing cause of the resultant disability or need for medical services. The first element is a question of legal causation; the second concerns medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618 (1981); Robert L. Leming, 44 Van Natta 2120 (1992). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

The Referee determined that claimant was a credible witness. The Board defers 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. Therefore, I conclude that she based her conclusion on her evaluation of the substance of claimant's testimony.

The only evidence regarding the alleged incident comes from claimant's testimony and her report of the incident about five months after it allegedly occurred. I find too many problems with the substance of claimant's testimony to find that claimant has met her burden of proof.

Claimant worked for the employer as a part-time registered nurse. Claimant was approximately eight months pregnant in late February 1990. Claimant alleged that, on February 23, 1990, while she and the charge nurse were helping a 180 pound patient back to bed, the patient became unable to support his weight and claimant and the charge nurse had to fully support him and get him into bed. Claimant alleged that she felt a strain and pain that night.

Claimant did not mention any back problems or pain associated with any lifting incident to anyone at work or to Dr. Cristofani, her treating obstetrician, whom she was seeing weekly. Claimant continued to work her regular part-time schedule over the next two and a half weeks before she left on maternity leave the first of March 1990. She had some back pain associated with her pregnancy. She first informed the employer of the alleged February 23, 1990 injury on July 19, 1990, after returning from maternity leave.

In explaining why she did not contemporaneously report the alleged incident, claimant stated that she has a high pain threshold, was leaving on maternity leave in two and a half weeks, and figured the pain would go away after her delivery. She explained that she did not report the back pain to her obstetrician because he was treating her for her pregnancy, not for a back problem. However, claimant testified that, as a registered nurse, she understands the importance of an accurate history.

In addition, this was not an unwitnessed incident in that claimant reported that the charge nurse was also present during the patient transfer. However, claimant did not call the charge nurse as a witness. Claimant argues that the employer also did not call the charge nurse and that the lack of this witness cuts both ways. However, claimant has the burden of proof on the issue of compensability, not the employer.

Finally, the only medical opinion regarding causation is from Dr. Medrano, the emergency room physician claimant saw on July 19, 1990, who stated: "Although several factors have contributed to the back pain, as per her history, I believe the major contributing cause was the initial strain at the onset of pain on March 1990 when she lifted a patient." (Ex. 8-1). Dr. Medrano did not identify the "several factors" she mentioned as having contributed to claimant's back pain, and based her opinion solely on claimant's history. Because I do not find claimant's history credible, I do not find this medical opinion based solely on that history to be persuasive.

Accordingly, I would find that claimant has failed to establish a compensable back injury claim.

In the Matter of the Compensation of
VICTORIA DELAO, Claimant
WCB Case Nos. 92-07238 & 92-06910
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Referee Lipton's order that awarded a $1,500 attorney fee for claimant's counsel's services in obtaining compensation for claimant without a hearing. On review, the issue is attorney fees.

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

On review, the employer contends that the attorney fee awarded by the Referee was 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 reviewing the record and considering the above factors, we conclude that $1,500 is a reasonable attorney fee. In reaching this conclusion, we have particularly considered the benefit secured for claimant, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

The employer argues that a fee of $500 would be a more appropriate fee. In support of its argument, the employer notes that claimant's attorney did not know the specific amount of time spent on the case, but "guessed" that 8-10 hours were spent. The record indicates that claimant's counsel filed two hearing requests and generated a "check-the-box" letter from claimant's physician. That "check-the-box" letter was the last exhibit in the record before the employer rescinded its denial. The letter is a medical opinion from Dr. Waldram, claimant's attending physician, concerning the causation of claimant's conjunctivitis.

Although claimant's attorney's services were limited, the amount of time devoted to a case is not the sole factor considered in determining a reasonable fee. Such factors as the benefit secured for the claimant and the value of the interest involved are also considered. Having considered all of the factors listed above, we conclude that the Referee's attorney fee award was reasonable.

Since attorney fees are not considered compensation, claimant is not entitled to a fee 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 March 4, 1993, as reconsidered on August 11, 1993, is affirmed.

January 20, 1994 Cite as 46 Van Natta 91 (1994)

In the Matter of the Compensation of
JAMES J. HINKLEY, Claimant
WCB Case Nos. 92-12151 & 92-12150
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) found that the SAIF Corporation had properly paid claimant interest for the period during which payment of permanent disability was stayed pending SAIF's appeal of a referee's order awarding the permanent disability; and (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are failure to pay interest, penalties and attorney fees.

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

In a January 16, 1992 order, a prior referee increased claimant's unscheduled permanent partial disability (PPD) award to 29 percent (92.8 degrees), and awarded him 53 percent (101.76 degrees) scheduled PPD. SAIF requested review of that order, and stayed payment of compensation pursuant to ORS 656.313(1)(a). The Board issued an order on July 31, 1992 affirming those awards, from which SAIF did not appeal.

Because claimant's PPD awards total more than 64 percent, in accordance with ORS 656.230(2) and OAR 436-60-060(1), SAIF began paying the awards in monthly installments on August 25, 1992. On September 4, 1992, SAIF paid claimant the interest accrued on the PPD benefits which had been withheld since the referee's January 16, 1992 order. Thereafter, claimant requested a hearing, contending that he is entitled to additional interest for SAIF's continued withholding of his total permanent disability award. The Referee found that unpaid monthly PPD payments do not constitute benefits that have been "withheld." Therefore, the Referee concluded that claimant is not entitled to additional interest on the remaining monthly PPD payments.

On review, claimant concedes that SAIF has a statutory right to pay the PPD awards in monthly installments. Nevertheless, he contends that that right comes with a duty to pay interest on the declining monthly balances through the final PPD monthly payment. We disagree.

ORS 656.313(1)(b) provides, in relevant part:

> "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 (emphasis added)."

In construing a legislative enactment, our first task is to discern the legislature's intent. See ORS 174.020. To that end, we look first to the text and context of the statute. If the language is unambiguous, we ordinarily apply it according to its plain meaning, without resort to legislative history. Satterfield v. Satterfield, 292 Or 780, 782 (1982). Only if the legislative purpose is unclear from the language of the enactment do we consider legislative history as an aid in determining legislative intent. State v. Leathers, 271 Or 236 (1975).

Here, both claimant and SAIF recite that the language of the statute is clear and unambiguous. However, the parties read ORS 656.313(1)(b) quite differently. Claimant argues that "benefits withheld" include the monthly balances due him on the PPD awards SAIF paid in installments pursuant to ORS 656.216(1). Therefore, claimant contends, because interest accrues "through the date of payment," interest continues accruing through the date SAIF made its final monthly payment to claimant. SAIF, on the other hand, argues that interest was due only on those amounts "stayed" in accordance with ORS 656.313(1)(b). Further, SAIF asserts, no amounts have been "withheld" or are "due" as a consequence of its election to pay claimant's awards over a twelve-month period as is its statutory right under ORS 656.216(1).

Noting that ORS 656.313(1)(b) states that interest on "benefits withheld" will be paid "at the rate specified in ORS 82.010," claimant argues that any interest due must be paid in accordance with all the provisions of ORS 82.010. Specifically, claimant contends, because SAIF's "account" with claimant has a "balance due," he earns interest on the unpaid declining balance through the date of the last monthly payment. See ORS 82.010(1)(a). We do not find claimant's interpretation consistent with the text and context of the statute. First, ORS 656.313(1)(b) does not merely refer to "benefits withheld." Rather, it specifically references "benefits withheld under this subsection." By its plain language, subsection (1) concerns permanent disability payments that have been "stayed" pending a carrier's appeal. ORS 656.313(1)(a).

Further, ORS 656.313(1)(b) states only that ORS 82.010 prescribes "the rate" at which any interest owed under the statute is to be paid. Nothing in the statute provides that interest due is to be paid in accordance with all the provisions set forth in ORS 82.010. If the legislature had intended all the provisions of ORS 82.010 to apply, we do not believe it would have employed the restrictive language "at the rate provided."

Finally, we note the absence of any reference in ORS 656.216(1) to ORS 656.313 to indicate a legislative intent to define PPD installment payments as "benefits withheld." ORS 656.216 has remained unchanged for many years. See Or Laws 1974 (Special Session), ch. 41, section 7. Under these circumstances, we find that ORS 656.216 is unaffected by the addition of subsections (1)(a) and (1)(b) to ORS 656.313. See Gantenbein v. PERB, 33 Or App 309, 319, rev den 282 Or 537 (1978) (The inclusion of specific matters in a statute implies a legislative intent to exclude related matters not mentioned).

For these reasons, we find that "benefits withheld" do not include balances due on PPD awards paid in monthly installments pursuant to ORS 656.216(1).

Alternately, claimant argues, the plain language of ORS 656.313(1)(b) itself ("benefits withheld . . . shall accrue interest . . . through the date of payment") means that interest accrues through the date the "final monthly" PPD payment is made. Claimant's interpretation is plausible. We are unable to discern from the language of the statute itself what the legislature intended to convey by the phrase "through the date of payment." Accordingly, we turn to the legislative history to assist us in determining what event(s) constitute(s) "payment."

Unfortunately, the legislative history surrounding ORS 656.313 is sparse, and does not assist our inquiry. Witness Dwinnell testified that:

> "Permanent disability [that has been stayed pending appeal], if ultimately found compensable, would be repaid to the worker with interest." (Interim Joint Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A.)

Senator Brenneman explained that:

> "Under this new law, an appeal stays payment of [permanent disability compensation]. Withheld benefits are never paid if the employer wins the appeal but are paid with 9 percent interest if the employer loses its appeal." (Senate Special Session on Workers' Compensation, May 7, 1990, Tape 4, Side A)

Neither is the term "payment" defined in amended ORS 656.313. We infer, however, that the term retains its customary meaning in workers' compensation law. Accordingly, we look to other statutes and rules within workers' compensation law for guidance. ORS 656.216 is the relevant statute concerning "the method of payment" of PPD awards. That statute, however, is not particularly enlightening. It provides only that a PPD award "may be 'paid' monthly."

Therefore, we next consider OAR 436-60-150, the administrative rule concerned with "the timely payment of compensation." OAR 436-60-150 provides, in pertinent part:

> "(6) Permanent disability . . . benefits shall be paid not later than the 30th day after:
>
> "(c) The date of any department order which orders payment of permanent partial disability . . . benefits, unless the order has been appealed by the insurer pursuant to ORS 656.313;
>
> "(d) The date any litigation authorizing permanent partial disability becomes final[.]
>
> "(7) Subsequent payments of permanent disability . . . benefits are made in monthly sequence as earned[.]"

Construing OAR 436-60-150(6)(d) and OAR 436-60-150(7) in concert with ORS 656.216(1), we conclude that an initial PPD installment payment paid within 30 days after the date of a final Board order authorizing PPD benefits, followed by subsequent monthly PPD payments, constitutes "payment" as that term is contemplated by ORS 656.313(1)(b). Therefore, we hold that while interest due under ORS 656.313(1)(b) accrues until the carrier makes full payment on an award of 64 degrees or less, interest due under ORS 656.313(1)(b) only accrues until the carrier makes its first installment payment on an award of more than 64 degrees. See ORS 656.230(2); OAR 436-60-060(1). Therefore, interest does not accrue during the period a carrier is making monthly PPD installment payments pursuant to ORS 656.216(1).

Applying our holding to the facts of this case, we find that SAIF's August 25, 1992 initial PPD payment, followed by its "subsequent" monthly payments, constitutes "payment" under ORS 656.313(1)(b). As SAIF paid claimant the interest accrued on the PPD benefits which had been withheld from January 16, 1992 through September 4, 1992, SAIF has already paid claimant the interest it owes him "through the date of payment."

Finally, although we have not previously addressed this specific issue, we find support for our reasoning in another case concerned with the payment of interest under ORS 656.313(1)(b). In Markus M. Tipler, 45 Van Natta 216 (1993), we observed that the interest payment requirement of ORS 656.313(1)(b) replaces the value of the PPD award that has been lost during the period payment was stayed. Our conclusion in the instant case is consistent with our holding in Tipler.

In sum, we conclude that PPD awards paid in installment payments do not constitute "withheld" benefits under ORS 656.313. Further, we conclude that where a carrier elects to make monthly payments pursuant to ORS 656.216(1), interest is owed through the date payment is made in accordance with OAR 436-60-150(6)(d) or OAR 436-60-150(7), not through the date of the final monthly payment. Consequently, SAIF properly paid claimant interest for the period during which permanent disability compensation payment was stayed.

As SAIF did not unreasonably resist the payment of compensation, it follows that no penalty or related attorney fee is due.

ORDER

The Referee's order dated January 13, 1993 is affirmed.

Board Member Gunn dissenting.

The majority concludes that claimant is not entitled to additional interest on "stayed" PPD awards. Because I disagree with the majority's holding that interest does not accrue during the period a carrier makes monthly PPD installment payments, I respectfully dissent.

Here, SAIF stayed payment of claimant's compensation under ORS 656.313. Ultimately, SAIF paid the "stayed" compensation in monthly installments. See ORS 656.216(1). Because SAIF's initial payment to claimant was delayed, its subsequent payments were likewise delayed. ORS 656.313(1)(b) provides that if ultimately found payable, "stayed" compensation accrues interest from the date of the order appealed from through the date of payment. I would hold that "the date of payment" is the date the carrier makes full payment on an award of 64 degrees or less or, alternately, the date the carrier makes its final installment payment on an award of more than 64 degrees. That is, as long as there is an outstanding balance of "stayed" compensation due, the carrier owes interest on the debt. Any other interpretation allows the carrier to avoid its obligation to pay interest "through the date of payment." Under the facts presented by this case, "through the date of payment" means through the date of SAIF's last monthly payment to claimant.

Therefore, in accordance with ORS 656.313(1)(b), SAIF should be required to pay claimant interest on each monthly payment on a declining balance basis until the entire PPD award has been paid in full.

In the Matter of the Compensation of
JERRY M. HOBBS, Claimant
WCB Case Nos. 92-15942, 92-13066, 92-15034 & 93-00131
ORDER DENYING MOTION TO DISMISS
Skalak & Alvey, Claimant Attorneys
Lundeen, et al., Defense Attorneys
Roy Miller (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys
Priscilla Taylor, Defense Attorney

Claimant has requested Board review of Referee Davis' order which: (1) upheld Astoria Golf & Country Club/Liberty Northwest's denials of claimant's aggravation claim for a cervical and lumbar condition; (2) found that Astoria/Liberty remained responsible for claimant's future compensation under his December 1988 compensable claim; (3) "affirmed all denials identified in this Opinion and Order"; and (4) declined to assess penalties and attorney fees. In response to the Board's acknowledgment of claimant's request for review, Lektro, Inc./EBI Companies has requested its dismissal as a party to this proceeding. The motion is denied.

FINDINGS OF FACT

Claimant filed hearing requests contesting denials issued by the following employers/insurers: Lektro, Inc./SAIF, Lektro/Liberty, Lektro/EBI, and Astoria/Liberty. The hearing requests were consolidated.

At the hearing, neither Lektro/Liberty nor Lektro/EBI appeared through counsel. The Referee recited that no party was contending that either Lektro/Liberty or Lektro/EBI were responsible for claimant's current claims. Noting no objection to this representation, the Referee stated that these cases would be dismissed. (WCB Case Nos. 93-00131 & 92-15034). Thereafter, the hearing proceeded with claimant, claimant's counsel, Astoria/Liberty, its counsel, and Lektro/SAIF, and its counsel in attendance.

Notwithstanding the Referee's representation at the hearing, neither the "Lektro/Liberty" nor the "Lektro/EBI" case was dismissed. Rather, in a final order addressing the merits of claimant's claims (and carrying all WCB Case numbers, including the "Lektro/Liberty" and "Lektro/EBI" case numbers), the Referee upheld "[a]ll denials identified in this Opinion and Order except that Astoria Golf and Country Club/Liberty Northwest Insurance Corporation remains responsible for claimant's accepted injury..." (Although the denials issued by Lektro/Liberty and Lektro/EBI were not listed in the "Issues" section of the order, each denial was identified in the "Findings of Fact" section of the order.)

Claimant timely requested Board review of the Referee's order. The Board mailed computer-generated letters to all parties to the proceeding acknowledging claimant's request for review. Thereafter, Lektro/EBI submitted its response requesting that the Board dismiss it as a party to this proceeding.

CONCLUSIONS OF LAW

Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).

Here, noting the parties' acknowledgment at hearing, Lektro/EBI reasons that no party is contending that it is responsible for claimant's claims. Consequently, Lektro/EBI seeks its dismissal as a party to this proceeding. We decline to grant Lektro/EBI's request.

Notwithstanding the Referee's representations at the hearing, Lektro/EBI was not dismissed as a party to the proceeding pursuant to a separate final, appealable order. Instead, the Referee's order expressly "affirmed" all denials mentioned in the order (which would necessarily include the "Lektro/EBI" denial). In any event, even if Lektro/EBI had been dismissed as a party, because its

dismissal would have been granted in the same order which addressed the merits of the other insurers' denials and since that order has been appealed, Lektro/EBI would remain a party to this proceeding. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992); Riley E. Lott, supra; Rual E. Tigner, 40 Van Natta 1789 (1988). However, considering the uncontested representations made by the Referee at the hearing, as a practical matter, Lektro/EBI's participation in this case will likely be nominal. Lott, supra.

Accordingly, Lektro/EBI's motion to dismiss is denied. As a result of this order, it will be necessary to implement a revised briefing schedule. Since we have recently received claimant's appellant's brief, the insurers' respondent's briefs shall be due 21 days from the date of this order. Claimant's reply brief shall be due 14 days from the date of mailing of the last timely submitted respondent's brief. Thereafter, this case shall be docketed for Board review.

IT IS SO ORDERED.

January 20, 1994 Cite as 46 Van Natta 96 (1994)

In the Matter of the Compensation of
DAVID L. LARGE, Claimant
WCB Case Nos. 93-01703 & 92-16205
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Hall.

Claimant requests review of Referee Quillinan's order that upheld the SAIF Corporation's denials of claimant's aggravation and "new injury" claims for claimant's right knee chondromalacia condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

On June 13, 1991, claimant suffered a right knee contusion at work. Dr. Matteri examined claimant on July 23, 1991 and suspected a torn medial meniscus. On August 26, 1991, Dr. Matteri performed arthroscopic surgery. He discovered no internal derangement except for mild chondromalacia.

SAIF accepted the claim for a right knee contusion. The claim was closed on October 14, 1991, with no permanent disability award.

On September 18, 1992, claimant fell at work, landing on his previously injured right knee. He sought medical treatment.

SAIF denied claimant's claims for a September 18, 1992 aggravation or "new injury," contending that claimant's employment with its insured did not cause his current right knee condition.

FINDING OF ULTIMATE FACT

Claimant's June 13, 1991 compensable injury directly caused claimant's right knee chondromalacia condition.

Claimant's September 18, 1992 fall at work caused his asymptomatic right knee chondromalacia condition to become symptomatic and require medical services. This injury, which combined with claimant's preexisting condition, is the major contributing cause of his resultant disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to carry his burden of proving the compensability of his current right knee condition. Specifically, the Referee determined that claimant did not prove that either the 1991 compensable injury or the 1992 work injury caused or worsened his current right knee chondromalacia condition.

Inasmuch as SAIF's denial is based on its assertion that claimant's employment did not cause his current right knee condition (chondromalacia), the claim is denied on causation grounds. Under these circumstances, we apply a two-step analysis. First, we address compensability, the threshold issue; then, if the claim is compensable, we consider whether the claim is properly processed as an aggravation or as a "new injury."

Compensability

SAIF relies on the opinion of Dr. Woolpert, contending that claimant's current problems result from a preexisting noncompensable chondromalacia condition. However, the medical evidence, including the opinion of Dr. Woolpert, indicates that claimant's 1992 work injury caused his right knee chondromalacia condition to become symptomatic and require medical treatment. (Exs. 17-4, 22). Drs. Matteri and Woolpert disagree only regarding the etiology of the chondromalacia condition. Dr. Matteri, claimant's treating physician, believes that the 1991 injury caused the chondromalacia; Dr. Woolpert believes that the chondromalacia is not injury-related. In light of this disagreement, we evaluate the persuasiveness of the medical opinions.

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). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no good reason to discount Matteri's opinion.

Dr. Matteri observed mild chondromalacia during the August 1991 surgery and later opined that the condition did not preexist the June 1991 injury, but resulted directly from it. (Exs. 8, 25). Dr. Matteri explained that he was aware of no pathological condition preexisting claimant's June 1991 injury and that he found no evidence of a "preexisting lesion." (Ex. 22). In our view, Dr. Matteri's opinion is well-reasoned and his conclusions are persuasive.

The only medical evidence contrary to Dr. Matteri's opinion concerning causation is provided by Dr. Woolpert, who examined claimant only once. Dr. Woolpert opined that claimant's then current symptoms were "due to preexisting chondromalacia of the patella unrelated to either injury." (Ex. 17-4). We find this opinion unpersuasive for several reasons.

We first note that there is no evidence that claimant had any right knee problems before the 1991 injury. In addition, because Dr. Woolpert did not examine claimant until 16 months after the 1991 injury, he was not in as good a position as Dr. Matteri to evaluate claimant's condition before and after the 1992 injury. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Finally, we do not find Dr. Woolpert's conclusion concerning causation particularly persuasive because he did not explain why he disagreed with Dr. Matteri's conclusion that the chondromalacia resulted from the first injury.

Under these circumstances, we find no good reason to discount Dr. Matteri's opinion, which is based in part on his first hand observation of claimant's right knee during surgery. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Accordingly, based on Dr. Matteri's persuasive opinion, we conclude that claimant's chondromalacia condition is compensable because it resulted directly from the 1991 work injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Alternatively, even if the chondromalacia condition was not directly related to the 1991 injury, we would interpret Dr. Matteri's opinion to support a finding that the injury was the major contributing cause of claimant's consequential condition. See ORS 656.005(7)(a)(A).

Claim Processing

Because we have determined that claimant's current right knee condition is compensable, the remaining issue is whether the claim is properly processed as an aggravation or a "new injury." Where, as here, the claimant has worked for the same employer who has been covered by the same insurer, we apply the "responsibility" principles of ORS 656.308(1) in determining under which claim the claimant's condition will be processed. See Peggy Holmes, 45 Van Natta 278 (1993).

In determining whether a claimant sustained a "new compensable injury" under ORS 656.308(1), the Supreme Court has held that ORS 656.005(7)(a)(B) is applicable. SAIF v. Drews, 318 Or 1 (1993). In other words, the Court has reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer if the injury is found to

be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, the Supreme Court has further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

Applying the aforementioned "responsibility" analysis to this situation, we conclude that claimant suffered a "new compensable injury." We base this conclusion on the following reasoning.

Based on Dr. Matteri's persuasive opinion, we have determined hat claimant's chondromalacia condition is compensable because it resulted directly from the 1991 work injury. Dr. Matteri also opined that claimant's September 18, 1992 fall at work caused the previously asymptomatic chondromalacia to become symptomatic. Because of these symptoms, claimant now needs medical services for his chondromalacia.

Finding no persuasive reason to discount Dr. Matteri's observations, we rely on Dr. Matteri's conclusion that the 1992 injury caused claimant's need for medical services for his right knee chondromalacia condition. Based on this opinion and the fact that claimant never previously required treatment for chondromalacia, we further conclude that claimant's September 1992 fall is the major contributing cause of his resultant disability and need for treatment. Accordingly, we hold that the claim is properly analyzed as a "new injury." See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) (Surgery for degenerative disc disease compensable because compensable strain injury had rendered preexisting asymptomatic condition symptomatic and the injury was the major contributing cause of claimant's resultant disability and need for surgery).

Inasmuch as claimant has finally prevailed against SAIF's denial of compensation, he 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 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 claimant's appellant's brief, claimant's counsel's 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 23, 1993 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial insofar as it pertains to a "new injury" claim is reversed. That portion of the denial is set aside and the claim is remanded to SAIF for processing as a "new injury." The remainder of the order is affirmed. For services at hearing and on review, claimant's counsel is awarded a $3,500 attorney fee, payable by SAIF.

In the Matter of the Compensation of
ARLENE M. LAWTON, Claimant
WCB Case No. 92-09681
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Hall.

Claimant requests review of that portion of Referee Spangler's order which upheld the SAIF Corporation's denials of claimant's injury/occupational disease claim for a low back condition. On review, claimant contends that SAIF is responsible for the claim because it failed to join to this proceeding an "out-of-state" employer with an accepted low back claim.

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

Claimant injured her low back in 1989 while working in Alaska. That claim was closed in 1990 with a 10 percent permanent disability award. In 1990, claimant moved to Oregon. She continued to experience low back pain, and was prescribed a TNS unit and treated conservatively.

In February 1992, claimant again injured her low back when helping lift and carry a rollaway bed while working as a housekeeper for an Oregon employer. SAIF issued a disclaimer of responsibility (naming the Alaska employer as being responsible) and claim denial in June 1992. (Ex. 54).

Finding that claimant's 1992 Oregon injury had combined with her 1989 Alaska injury, the Referee concluded that ORS 656.005(7)(a)(B) would normally apply. Nevertheless, relying on SAIF v. Drews, 117 Or App 596 (1993), the Referee reasoned that ORS 656.005(7)(a)(B) was not applicable in the responsibility context. See ORS 656.308.

Subsequent to the Referee's order, the Supreme Court held that ORS 656.005(7)(a)(B) is applicable when determining whether responsibility shifts to a subsequent employer under ORS 656.308(1). SAIF v. Drews, 318 Or 1 (1993), supra. In reaching that conclusion, the Court held that ORS 656.005(7)(a)(B) is applicable regardless of whether a "preexisting condition" is compensable or noncompensable.

In other words, the Supreme Court reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, the Supreme Court has further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

Here, the Referee drew a distinction between the "in-state" and "out-of-state" claims. Specifically, the Referee concluded that ORS 656.308 was not applicable where the first employer is "out-of-state," and not subject to Oregon Workers' Compensation Law. See ORS 656.005(25); 656.023. See Progress Quarries v. Vaandering, 80 Or App 160 (1986).

We tend to agree with the Referee's reasoning that ORS 656.308 is not applicable when an "out-of-state" employer is presently responsible for a condition. Nevertheless, we need not resolve that issue because, even if ORS 656.308 were applicable, the record does not establish that claimant suffered a new compensable injury while working for SAIF's insured.[1]

The medical evidence indicates that claimant's Alaska injury involved her lower left back with pain radiating into the left leg. (Exs. 2-1, 3). Claimant's Oregon injury also involved left lower back pain. (Ex. 52). On the Oregon 801 form, claimant stated that she had previously injured her left lower back in 1989. Further, the history that Dr. Woolpert obtained from claimant indicated that claimant continued to be symptomatic and sought treatment for her 1989 injury after moving to Oregon. (Ex. 56-2). He subsequently concluded that claimant's 1989 injury was a preexisting condition that waxed and waned with symptomatic exacerbations that included her current injury. (Ex. 58-2).

In light of this, we find that claimant's "out-of-state" injury and subsequent condition represents a "preexisting condition" under ORS 656.005(7)(a)(B). Moreover, this evidence also establishes that this "preexisting condition" combined with claimant's "Oregon" injury. Thus, to prove the compensability of claimant's resultant disability, the record must establish that the February 1992 "Oregon" injury is and remains the major contributing cause of her disability and need for treatment. See ORS 656.005(7)(a)(B).

After conducting our review of the medical and lay evidence, we are not convinced that this record satisfies the requirements of ORS 656.005(7)(a)(B). For the reasons expressed by the Referee, we find Dr. Woolpert's opinion to be more persuasive than that of Dr. Pitchford.

Furthermore, even if we were to agree with claimant that Dr. Woolpert's opinion is not persuasive, we find Dr. Pitchford's opinion inconclusive. Pitchford provided mainly conclusory "yes" or "no" answers to questions put to him. Moreover, within the same paragraph Pitchford stated that claimant's current condition is most likely an aggravation of her 1989 injury, but may represent a new injury. In light of such contradictory statements, we do not find that Dr. Pitchford's opinion supports a finding that claimant's 1992 "Oregon" injury is the major contributing cause of her current condition.

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[1] Copies of the disclaimer/denial were mailed to the Alaska employer and to the Alaska insurance company. Therefore, SAIF complied with the statute, even if applicable.

ORDER

The Referee's order dated March 18, 1993 is affirmed.

Board Member Westerband specially concurring.

I agree that SAIF's denial must be upheld, under the law and given the evidence. I write separately to express my concern about the impact of the law on this claimant and on injured workers similarly situated.

Claimant came to Oregon suffering from a chronic low back strain that she sustained in an industrial accident in Alaska. She received a permanent disability award under Alaska's workers' compensation law. In the present case, we have decided that, although "compensable" under the laws of another state, claimant's chronic strain is a "preexisting condition" within the meaning of ORS 656.005(7)(a)(B), and, therefore, the major contributing cause standard applies. See, Michael R. Holt, 45 Van Natta 849 (1993); Jack C. Gribe, 45 Van Natta 983 (1993). Although that conclusion is correct, I believe it leads to a harsh result that I do not believe the legislature even contemplated when it enacted ORS 656.005(7)(a)(B).

In upholding SAIF's denial, we have essentially found that, although materially caused by a work-related injury at SAIF's insured, claimant's current strain condition is an aggravation of her chronic strain injury for which the Alaska insurer is responsible. The problem with that finding is that our holding is unenforceable against the Alaska insurer. Not coincidentally, the Alaska insurer denies responsibility for an aggravation on the ground that claimant suffered a new injury in Oregon. Thus, although claimant's condition is undisputedly work related, either as an aggravation or a new injury, she is likely to go uncompensated solely because of conflicting workers' compensation laws of the two sovereign states.

Did the legislature contemplate that by enacting ORS 656.005(7)(a)(B), workers injured in covered Oregon employment would go uncompensated because they have preexisting "compensable" conditions? I think not.

The enactment of ORS 656.005(7)(a)(B) was not the first time that the legislature failed to contemplate such a problem. In Miville v. SAIF 76 Or App 603 (1985), the court faced and had to "fix" such a problem. There, the worker suffered a compensable back injury in Oregon. He later moved to Washington where he suffered another back injury for which he was compensated by Washington for an "aggravation," pursuant to the workers' compensation laws of that state. Before returning to Oregon, he had also suffered back injuries while working for a hospital in Indiana. The Board found that the out-of-state injuries contributed independently to the worker's worsened condition, thereby relieving SAIF of liability under the original claim. On review, the Court of Appeals reversed, saying the following:

> "Here, if claimant's injuries had occurred on the job in Oregon, the [last injurious exposure rule] would assign liability to the later employer if the injuries contributed independently to the disability. If, on the other hand, those injuries had occurred off the job, Grable would apply and we would hold the first employer responsible.
>
> "The rules in Grable and Smith arose in a context in which Oregon has 'control' over assignment of responsibility, either to a subsequent employer, if there is one ***, or to the original employer, if there is not. Oregon can apply its rules consistently between Oregon employers. Here, however, Oregon does not have that control, because three of the later injuries occurred out of state. If, for example, we were to hold here that the Indiana incidents were new injuries, rather than aggravations of the Oregon injury, and were to apply the rule in Smith, claimant would have no means of enforcing that result against the Indiana employer. Similarly, if claimant had filed a claim in Indiana and Indiana had determined that the incidents were aggravations of the Oregon injury *** and had a rule which required the first employer to remain responsible, claimant would have no means of enforcing that result against the Oregon employer. In either case, he would remain uncompensated for injuries which were clearly work related. That would be contrary to the policy of the workers' compensation system!" (76 Or App at 606-607).

To prevent this from happening, the court ruled that where the original Oregon injury materially contributes to the claimant's present condition, even though the out-of-state injuries contribute independently to the present disability, the claimant will be compensated in Oregon for the worsening provided he first files a claim in the other states and obtains a final determination from them that his claim is not compensable. (Id).

Here, we have a similar conflict of laws problem. We are unable to avoid it here, unlike in some cases where a "new injury" in Oregon is proven by the evidence. See, Michael R. Holt, supra, and Jack C. Gribe, supra. Regardless of how any specific case is decided on the facts, the Board lacks the power to insure by rule of law, that injured workers will not go uncompensated for injuries which are clearly work related. Perhaps the appellate courts can find an answer, as was done in Miville. In any event, the power to address this problem exists in the legislature, where the problem was not contemplated when ORS 656.005(7)(a)(B) was enacted.

Board Member Hall dissenting.

I find that claimant has proven that her Oregon employment is the major contributing cause of the condition for which she filed her Oregon claim, and, therefore, dissent.

Claimant was found to be credible. There is no dispute over the fact that claimant did suffer an acute injury on the job in Oregon. Claimant filed an Oregon claim for the diagnosed condition of "lumbosacral strain," which was anticipated to resolve "uneventfully." (Exs. 52, 53). We must keep the nature of the claimed condition in perspective when determining causation.

No one is claiming that the Oregon employer should be responsible for what was (and probably still is) the compensable Alaska condition. Whether claimant's Oregon strain remains the cause of future problems (e.g. permanent disability) or whether she will recover from her Oregon strain with future problems attributable to the Alaska claim is a question not currently before us. The question now is causation of a strain that required medical treatment and time loss in Oregon.

While claimant suffered from chronic low back pain as a result of her Alaska injury, I am convinced that she suffered an acute injury in February 1992 as a result of her Oregon employment. Claimant was rendered disabled from working, where she had been working even with the chronic pain from her Alaska injury. I am convinced that claimant's Oregon injury is the major contributing cause of the condition for which she filed her Oregon claim.

In evaluating the medical opinions, I find the opinion of Dr. Thomas Pitchford, the treating doctor, more persuasive. His opinion that claimant's Oregon injury is the major contributing cause of her current claimed lumbosacral strain is consistent with his opinion that claimant's current condition is also likely an aggravation of the Alaska condition. Again, we must keep the nature of the claimed condition in perspective.

Dr. Keith Woolpert offers opinions based on speculation. His first opinion is admittedly rendered without benefit of any reports from claimant's past and is framed only in terms of an "impression" because: "It is somewhat difficult to evaluate the major cause of the patient's problem inasmuch as we don't have previous records indicating what the problem accurately is." (Ex 56-4). Dr. Woolpert's second report is of little value because it is again framed only in terms of vague impressions. (Ex 58-2).

In the Matter of the Compensation of
MICHAEL J. MELVIN, Claimant
WCB Case Nos. 92-05534, 92-05533 & 92-03604
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Kelly E. Ford, Defense Attorney
Nancy Marque (Saif), Defense Attorney

Claimant requests reconsideration of our December 22, 1993 Order on Review which concluded that Liberty Northwest Insurance Corporation was solely responsible for payment of the Referee's assessed fee award of $4,000 for services rendered by claimant's counsel at hearing in prevailing against Liberty's denial of compensability. Claimant contends that his counsel is also entitled to an assessed fee under ORS 656.382(2) for services rendered on review. We agree.

Claimant filed claims for a leg injury against Jack Foust Logging, the noncomplying employer, and Olson & Berg Logging, Liberty's insured. Liberty, on behalf of its insured, denied the compensability of and responsibility for the claim. SAIF, as processing agent for the noncomplying employer, initially denied the compensability of the claim, but later entered a stipulation by which it rescinded its denial and accepted the claim. However, the noncomplying employer requested a hearing contesting the compensability of the claim.

At hearing, the Referee found the claim compensable and assigned responsibility to Liberty. The Referee also awarded claimant's counsel an assessed fee of $4,000, payable in equal shares by Liberty and SAIF. SAIF requested Board review, contending that the entire assessed fee award should be paid by Liberty, the responsible insurer. We agreed and modified the Referee's order accordingly.

Due to Liberty's compensability denial and the noncomplying employer's hearing request, we find that claimant's right to compensation was at risk at hearing. Further, given our de novo review authority, claimant's compensation remained at risk on Board review. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993). Consequently, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, payable by Liberty.

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 $350, 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. We have also considered that, inasmuch as attorney fees are not compensation, claimant's counsel is not entitled to an attorney fee for his services on Board review regarding the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, we withdraw our December 22, 1993 order. On reconsideration, as modified herein, we adhere to and republish our December 22, 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
CAROLANN O'NEIL, Claimant
WCB Case Nos. 92-14886 & 92-04704
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Lundeen, et al., Defense Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee Podnar's order that: (1) set aside its denials of claimant's current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings, except for the last paragraph.

ULTIMATE FINDINGS OF FACT

Claimant's 1984 compensable injury with Liberty's insured was the major contributing cause of her L5-S1 herniated disc.

Claimant's L5-S1 herniated disc does not involve the same condition accepted by SAIF in 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current low back condition was related to her 1984 injury with Liberty's insured. Finding that the condition SAIF accepted in 1990 is the same condition as that accepted by Liberty in 1984, the Referee held that, under ORS 656.308(1), responsibility shifted to SAIF. We find Liberty responsible.

Claimant's 1984 back injury with Liberty's insured was diagnosed as both left lower back pain with a possible ruptured L4-L5 disc, and acute lumbosacral and sacroiliac sprain. The claim was originally closed in January 1985, and then reopened for continued treatment. (Exs. 5, 5A - 5E, 6A). The claim was finally closed by an April 1985 Determination Order that did not award permanent disability. (Ex. 7). Claimant subsequently injured her back again in 1990. SAIF, the insurer on the risk, accepted claimant's "low back strain" injury claim. (Ex. 16). That claim was closed in August 1990, without a permanent disability award. (Ex. 20).

In July 1991, claimant experienced severe disabling pain in her left hip and leg while she was walking across a street. The pain caused her left leg to give out, and she fell. (Exs. 24-1, 32-1). Two hours later, her left leg became numb. (Ex. 32-1). An MRI confirmed that claimant had an L5-S1 herniated disc. (Ex. 24-1).

To establish the compensability of her current herniated disc condition, claimant must prove that that condition was caused, in major part, by either her 1984 or her 1990 accepted condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). No party contends, nor does any physician opine, that claimant's 1990 industrial accident with SAIF's insured caused her herniated disc. Accordingly, to prevail, claimant must establish that her 1984 accepted condition with Liberty's insured was the major contributing cause of her herniated disc.

The record contains the opinions of four physicians. Dr. Coker examined and treated claimant after her disc herniated; he performed an L5-S1 surgery in February 1992. (Ex. 26). Dr. Hoffman examined and treated claimant in October 1992, after she continued to experience back and leg symptoms. (Ex. 32). Both Coker and Hoffman opined that claimant's back problems originated with her 1984 compensable injury.[1] (Exs. 24, 30-1, 32-3, 34-36). Coker further opined that claimant's herniated disc is the end result of a long-standing degenerative process. (Ex. 30-1). Hoffman stated that

[1] Dr. Coker's opinion actually states that claimant's problems began in 1982. He later corrected the date to 1984. (Ex. 36).

claimant's continuing symptoms in October 1992 were "due to a combination of recurrent disc herniation and the progression of degenerative disc disease with relative instability." (Ex. 32-3). Both Coker and Hoffman concurred with claimant's counsel's written statement that claimant's increase of symptoms in August 1991, degenerative disc process, disc herniation and need for surgery were caused, in major part, by her 1984 compensable back injury. (Exs. 35, 36).

To the contrary, Dr. Coletti, SAIF's record review physician, and Dr. Vore, one of claimant's treating physicians in 1990, concluded that her current disc herniation was not related to either of her industrial accidents. (Exs. 28, 31).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

We find no persuasive reason not to defer to the opinions of Drs. Coker and Hoffman. They were claimant's treating physicians after her disc herniation; therefore, they are in a better position to render opinions on the cause of claimant's herniation. Lloyd G. Currie, 45 Van Natta 492 (1993). Further, both doctors' opinions are based on extensive histories, physical examinations, and claimant's radiological studies.

Most importantly, both Dr. Coker and Dr. Hoffman addressed the causal connection between claimant's 1984 injury and her current condition. We find persuasive their reasoning that claimant's current condition was the result of a degenerative process that started with claimant's 1984 compensable back injury with Liberty's insured.

Finally, both doctors have persuasively refuted Dr. Coletti's contrary opinion. Dotty C. Fowler, 45 Van Natta 1649 (1993). Coker disagreed with Coletti's "spontaneous herniation" diagnosis on the ground that there was evidence that claimant had a long-standing degenerative disease. (Ex. 30-1). Hoffman also pointed out that Coletti had neither examined claimant, nor reviewed her radiological studies. (Ex. 34). See Luis Sanchez, 45 Van Natta 86 (1993).

We find further compelling reasons for discounting the opinions of Drs. Coletti and Vore. Coletti concluded that claimant had experienced a spontaneous disc herniation "for the simple reason that disc herniations are actually known to occur untreated to industrial exposure." (Ex. 28-2). Inasmuch as that conclusion was not accompanied by a thorough explanation, we find that opinion unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). We also find Dr. Vore's opinion unpersuasive, because he last examined claimant over a year before she sustained her disc herniation (Exs. 17, 19), and because his opinion consists of an unexplained "check-the-box" letter. See David J. Rowley, 45 Van Natta 1659 (1993). For these reasons, we give little weight to either of those doctor's opinions.

In sum, we rely on the opinions of Drs. Coker and Hoffman. Moreover, we conclude that their opinions are sufficient to meet claimant's burden to establish that her 1984 compensable injury with Liberty's insured was the major contributing cause of her herniated disc. Accordingly, claimant's current condition is compensable under ORS 656.005(7)(a)(A).

The Referee concluded that, pursuant to ORS 656.308(1), SAIF is responsible for claimant's current back condition. We disagree. ORS 656.308(1) applies to shift responsibility to the later carrier if the worker's current condition involves the same condition as that accepted by the later employer. Smurfit Newsprint v. DeRossett, 118 Or App 368, 371-72 (1993). Here, the record does not establish that claimant's current herniated disc condition involves the same "low back strain" condition SAIF accepted in 1990. Hence, ORS 656.308(1) does not apply to shift responsibility to SAIF. See Armand J. DeRossett, 45 Van Natta 1058 (1993); John P. Lambert, 45 Van Natta 472 (1993). Moreover, even if ORS 656.308(1) was applicable, the evidence does not establish that claimant's 1990 injury was the major contributing cause of her current condition. Accordingly, we reverse that portion of the Referee's order that shifted responsibility for claimant's current back condition to SAIF. Liberty is responsible for claimant's current back condition.

Liberty denied only responsibility for claimant's current back condition. (Tr. 5).[2] SAIF, however, denied both the compensability of, as well as responsibility for, that condition. When a claimant's compensation is placed at risk by the non-responsible insurer, that insurer is held responsible for an assessed attorney fee. SAIF v. Bates, 94 Or App 666 (1993); Roy W. Riggs, 45 Van Natta 2003 (1993). Accordingly, because SAIF, the non-responsible insurer, put claimant's compensation at risk, it remains responsible for the Referee's $2,800 attorney fee for claimant's counsel's services at the hearing level.

Moreover, because of our de novo review, claimant's compensation remained at risk on Board review. Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Therefore, SAIF is also responsible for an assessed attorney fee for claimant's counsel's services on review. ORS 656.382(2); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $500. In reaching this decision, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 12, 1993 is affirmed in part and reversed in part. The SAIF Corporation's denials are reinstated and upheld. Liberty Northwest Insurance Corporation's denial is set aside and the claim is remanded to Liberty for processing according to law. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded $500, to be paid by SAIF.

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[2] Liberty did not respond to claimant's claim for compensation. Therefore, claimant filed a "de facto" denial hearing request. At the hearing, Liberty's counsel admitted that Liberty was denying only responsibility.

In the Matter of the Compensation of
LAURA RINI, Claimant
WCB Case No. 92-16377
ORDER ON REVIEW
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee Neal's order that upheld the self-insured employer's denial of claimant's medical services claim for her neck, low back, right arm, and right leg condition. On review, the issue is compensability.

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

Claimant seeks not only payment of her denied medical treatment, but also requests temporary and permanent disability awards. Inasmuch as neither temporary or permanent disability requests were made at the time of hearing, we decline to address those issues on review.

In any event, because claimant's 5-year aggravation rights under her 1979 claim have expired, any further request for claim reopening would be subject to the Board's "own motion" authority under ORS 656.278. Thus, since this case pertains to claimant's appeal of a Referee's order under ORS 656.295, we would lack authority to grant claimant's disability award requests even if the requests had been timely raised at hearing.

Finally, tracing her complaints back to her 1979 compensable injury, claimant reasserts that her current condition is causally related to her industrial incident. Dr. Jura, claimant's current attending physician, has concluded that claimant's chronic conditions are the residual effects of her 1979 compensable injury. (Ex. 91-19). Nevertheless, Dr. Jura, who only recently began treating claimant, also acknowledged that he had not examined most of claimant's prior medical history and was unable to offer an opinion concerning earlier examiners' conclusions that claimant's symptoms were non-organic.

In light of Dr. Jura's admitted unfamiliarity with claimant's complete medical history, we agree with the Referee's decision to discount the physician's opinion. This conclusion is further fortified when Dr. Jura's opinion is compared with the thorough report offered by the First Northwest Health consultants, who agreed with previous examiners that there were "non-organic problems affecting [claimant's] perception of her condition." (Ex. 89-6).

Dr. Patton, a physician who had treated claimant periodically from 1981 through 1991, agreed with the consultants' findings. (Ex. 91). In doing so, Patton stated that although x-rays had revealed mild retrolithesis in the L5-sacrum area, no radicular symptoms were noted. Dr. Patton further concurred that claimant's subjective complaints outweighed her physical findings and that somatization was evident.

In light of such opinions, we are unable to conclude that claimant's current complaints are causally related to her 1979 compensable injury. We reach such a conclusion whether claimant is required to prove that her injury was "the major" or "a material" contributing cause of her current need for medical treatment.

ORDER

The Referee's order dated March 23, 1993 is affirmed.

January 20, 1994 Cite as 46 Van Natta 106 (1994)

In the Matter of the Compensation of
MARTIN O. TADLOCK, Claimant
WCB Case No. 92-10524
ORDER ON RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

The self-insured employer has requested reconsideration of our November 19, 1993 Order on Review that reversed a Referee's order upholding its denial of claimant's head and upper body injury claim. On December 17, 1993, we abated our order to allow claimant an opportunity to respond. Claimant's response and the employer's reply have been received.

On reconsideration, the employer objects to that portion of our order that found that claimant, a corrections officer and Deputy Sheriff, is a "peace officer" who is subject to the policy set out in the employer's Public Safety Standards and Training Manual. Specifically, the employer asserts that claimant does not have 24 hour arrest authority. Therefore, the employer argues that we erred in concluding that claimant's injury, which occurred when he was off-duty, arose out of and in the course and scope of his employment. We disagree.

The employer's Public Safety Standards and Training Manual sets out the employer's policies, including those which apply to all employees, not just those who have 24 hour arrest authority. (Ex. 4-1). Accordingly, even assuming that claimant does not have such authority, we conclude that he is subject to those policies and expectations articulated in the manual which are not limited to employees who do have 24 hour arrest authority.

A Sheriff's letter introducing the manual expressly states that this employer expects more from its employees than a normal employer would. (Ex. 4-1). For example, even an off-duty employee may be required to take action in his or her official capacity. (Ex. 4-3-4).

In this case, claimant displayed his Sheriff's Deputy badge in an attempt to "defuse" aggression directed against him when he was off-duty. We have no reason to doubt the purpose of claimant's action. Nonetheless, contrary to claimant's expectation, his act of self-identification provoked a physical assault.

As we read the employer's Public Safety Standards and Training Manual, claimant's conduct conformed with that required and anticipated by the employer. There is no contention that claimant acted inappropriately and, as stated in our prior order, the problem came to claimant, he did not create it. Considering the threatening circumstances, we are persuaded that claimant had a work-related duty to respond as he did. Unfortunately, claimant was injured because he identified himself as a Sheriff's Deputy. Accordingly, on these facts, we continue to conclude that claimant was acting within the course and scope of his employment when he displayed his badge. Consequently, claimant's resultant injury is compensable, whether or not he has 24 hour arrest authority.

We withdraw our November 19, 1993 order. On reconsideration, as supplemented herein, we republish our November 19, 1993 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

January 20, 1994 Cite as 46 Van Natta 107 (1994)

In the Matter of the Compensation of
ARCHIE M. ULBRICH, Claimant
WCB Case No. 92-05765
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband, Gunn and Neidig.

Claimant requests review of that portion of Referee Neal's order which (1) upheld the insurer's denial of his cardiac atrial fibrillation condition; and (2) did not assess a penalty for allegedly unreasonable claim processing. The insurer cross-requests review of that portion of the order which set aside its denial of claimant's gastroesophageal reflux condition. On review, the issues are compensability and penalties and related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Gastroesophageal Reflux

Pursuant to ORS 656.005(7)(a)(A), the Referee concluded that claimant's June 16, 1986 compensable injury was the major contributing cause of his gastroesophageal reflux condition. We agree with and adopt the Referee's conclusion with regard to this condition.[1]

Atrial Fibrillation

In order to prove compensability, claimant must establish either that his current condition and need for treatment were directly caused by the industrial accident (in which case, the material contributing cause standard applies) or that the current condition arose as a consequence of the compensable injury, which is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992).

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[1] Dr. Garvie, gastroenterologist, stated that claimant's gastroesophageal reflux was not caused by his compensable injury and subsequent treatment with antidepressants. Rather, a preexisting condition was exacerbated by the injury. Accordingly, claimant's condition may properly be analyzed under ORS 656.005(7)(a)(B). In any event, the "major contributing cause" standard would apply, and of course, our decision would be the same.

Claimant's original 1986 injury involved, in part, a severe right foot fracture. Claimant is not contending that his work accident was the cause of his heart condition but, rather, that the condition arose as a consequence of the compensable injury. Specifically, he experienced atrial fibrillations within one or two days following his third, fourth and fifth foot surgeries. These surgeries were related to claimant's compensable injury. Thus, claimant must prove that his June 16, 1986 compensable injury is the major contributing cause of the heart condition. The Referee concluded that claimant's compensable injury was not the major contributing cause of his atrial fibrillation. We disagree.

On the day following claimant's September 23, 1988 right foot surgery, claimant experienced the first atrial fibrillation and was examined at that time by Dr. Wilson, cardiologist. Dr. Wilson neither related that episode nor the two subsequent atrial fibrillation episodes to claimant's June 16, 1986 accident.

Dr. Kremkau, cardiologist, also examined claimant. She stated that the cause of the atrial fibrillations was undetermined. She further stated that hyperthyroidism was a possible cause, and should be excluded.

Dr. Hansen, orthopedic surgeon, performed right foot surgery on claimant two times (March 6, 1990 and April 9, 1991), each shortly followed by atrial fibrillations. Dr. Hansen concluded that claimant's heart problems were related to the stress of the surgeries and medications. (Exs. 96, 97). Hansen further identified claimant's possible below-knee amputation as a stress contributor. (Ex. 96).

Claimant's treating physician, Dr. Intile, internist, opined that claimant's surgeries were the major contributing cause of his atrial fibrillation. (Tr. 13, Ex. 109).

When the medical evidence is divided, we give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no such reasons.

Dr. Intile treats approximately 200 patients for atrial fibrillations (or cardial arrythmias). He began treating claimant for his fibrillation condition in January 1992. In many patients, Dr. Intile has observed a direct causal relationship between the onset of atrial fibrillations and stress. Moreover, several of his patients, including claimant, have developed the atrial fibrillations shortly following surgery. After ruling out other potential causes of the condition, Dr. Intile opined that in claimant's case, the atrial fibrillation developed as a "direct result" of the physical and mental stresses associated with surgery, especially the last three surgical procedures. He explained that if the atrial fibrillation had occurred after only one of the surgeries, it would be reasonable to dismiss the appearance of a causal relationship as a mere coincidence. However, in claimant's case, it developed shortly after surgery three times. Dr. Intile stated that beyond doubt, the cardiac arrythmias are causally related to the surgeries. Dr. Hansen, who performed the last surgery, agreed.

In contrast, we do not find the other medical opinions in the record well reasoned or persuasive. Dr. Wilson's opinion is conclusory, and addresses a question that is not at issue here; whether claimant's fall, wherein he injured his foot, caused the atrial fibrillation. Dr. Kremkau opined that the cause is "unknown," and believed that hypothyroidism must be ruled out (which, in fact, was done by Dr. Intile). Dr. Woll did not offer any explanation for his concurrence with Dr. Kremkau's opinion.

We are persuaded by the opinions of Intile and Hansen. Accordingly, we conclude that claimant's compensable injury was the major contributing cause of his atrial fibrillation. Therefore, we set aside the insurer's denial.

Penalties and Attorney Fees for Alleged Unreasonable Denials

We adopt the Referee's conclusion with regard to this issue.

Claimant is entitled to an assessed attorney fee for finally prevailing against the insurer's atrial fibrillation 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 concerning this issue is $3,300, 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 briefs), the complexity of the issue, and the value of the interest involved.

Claimant is further entitled to an assessed attorney fee for prevailing over the insurer's cross-request for review on the issue of compensability of claimant's gastroesophageal reflux 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 the gastroesophageal reflux condition 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 cross-respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 24, 1992 is reversed in part and affirmed in part. That portion of the order which upheld the insurer's denial of claimant's atrial fibrillation 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 Board review concerning compensability of the atrial fibrillation condition, claimant's attorney is awarded an assessed fee of $3,300, to be paid by the insurer. The remainder of the order is affirmed. For services on Board review concerning the gastroesophageal reflux condition, claimant's attorney is awarded an assessed attorney fee of $800, to be paid by the insurer.

Board Member Neidig dissenting:

The majority relies on the opinions of claimant's attending physician, Dr. Intile, internist, and Dr. Hansen, orthopedic surgeon, to support a causal relationship between claimant's heart condition and his compensable foot injury and resultant surgeries. Because those opinions are provided by physicians who are not specialists in cardiology, I do not find them persuasive. Accordingly, I dissent.

Where the medical opinions are divided, we generally rely on physicians who are specialists in the field in question. Abbott v. SAIF, 45 Or App 657, 661 (1980). Furthermore, in this case, there is no reason to give special deference to the opinion of the treating physician, because resolution involves expert analysis rather than expert external observation. See Allie v. SAIF, 79 Or App 284, 287 (1986).

Here, Dr. Intile did not begin treating claimant for his atrial fibrillation condition until ten months after the last episode, and after the condition was stabilized with medication. Dr. Intile did not diagnose claimant's condition, but merely prescribes medication to control the condition. Dr. Intile's testimony, on the whole, indicates that his opinion is based almost entirely on a temporal relationship between the foot surgeries and the atrial fibrillations. Likewise, Dr. Hansen "assumes" that claimant's heart problems are related to the stress of surgery.

Because I am not persuaded by the opinions of non-cardiologists temporally relating claimant's heart condition to his foot injury and resultant surgeries, I would conclude that claimant has failed to prove that his compensable foot injury is the major contributing cause of his atrial fibrillations.

January 20, 1994 Cite as 46 Van Natta 109 (1994)

In the Matter of the Compensation of
LARRY E. WESTGAARD, Claimant
WCB Case No. 93-01549
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Livesley's order which: (1) declined to assess a penalty under ORS 656.268(4)(g) where the Referee increased claimant's permanent disability award by 25 percent; and (2) declined to assess a penalty-related attorney fee under ORS 656.382(1) for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are penalties and attorney fees.

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

Subsequent to the Referee's order, we held that a penalty under ORS 656.268(4)(g) is available only when the Department awards the requisite increase in permanent disability benefits on reconsideration. See Vena K. Mast, 46 Van Natta 34 (1994); Cynthia L. Luciani, 45 Van Natta 1734 (1993). Thus, the Referee did not err in declining to assess a penalty under ORS 656.268(4)(g).[1]

ORDER

The Referee's order dated June 2, 1993 is affirmed.

[1] Although a signatory to this order, Board Member Gunn directs the parties to his dissent in Vena K. Mast, supra.

In the Matter of the Compensation of
RONALD W. HORTON, Claimant
WCB Case No. 92-15117
ORDER ON REVIEW
Bradley A. Peterson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Hall.

The self-insured employer requests review of that portion of Referee Nichols' order which set aside its denial of claimant's herniated cervical disc and left upper directed pain conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness Defense

In its appellate briefs, the employer contends that claimant's claim is barred because it was not timely filed pursuant to ORS 656.265(1). ORS 656.265(5) provides that "[t]he issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death." The insurer did not litigate this issue at the hearing, nor did the Referee address it in her order. (See Tr. 2). Since the employer failed to properly raise the issue at the hearing, we need not address the merits of the issue. Lorenzo G. Perez, 42 Van Natta 1127, 1128 (1990); see also Mary Davenport, 45 Van Natta 242 (1993); Jefferson S. Case, 44 Van Natta 1007, 1008 n.1 (1992).

Compensability

We affirm and adopt the Referee's order which found claimant's herniated cervical disc and left upper directed pain conditions to be compensable, with the following supplementation.

Relying on the opinions of Drs. Belza and Newby, the Referee found that claimant sustained a work injury which is the major contributing cause of his current cervical condition and need for surgery. We agree with the Referee's findings and conclusion. The opinion of Dr. Altrocchi, consulting neurologist, also supports compensability. (See Exs. 9 and 10). In addition to the evidence relied on by the Referee, we find Dr. Altrocchi's opinion persuasive.

Attorney Fees

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 29, 1993 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the self-insured employer.

January 21, 1994 Cite as 46 Van Natta 111 (1994)

In the Matter of the Compensation of
ALLETHE P. YNGSDAHL, Claimant
WCB Case No. 92-05969
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of that portion of Referee M. Johnson's order that declined to grant permanent total disability. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

Claimant, 69 years of age at hearing, injured her back and right foot in 1983 while employed as a stock room clerk by the self-insured employer, a chain retail store. The injury occurred when claimant slipped and fell in a puddle of water.

Claimant was treated conservatively. Beginning in September 1985, claimant was referred to vocational rehabilitation services to aid in returning to work with the employer. Efforts were directed at developing a job to appropriately accommodate claimant's physical disabilities. These efforts continued through May 1992.

Claimant received 20 percent unscheduled permanent disability and 10 percent scheduled permanent disability by a June 5, 1987 Determination Order. She received an additional 25 percent unscheduled permanent disability in December 1987 by stipulation.

In February 1989, claimant underwent a fusion of the first metatarsal joint in the right foot. In December 1989, claimant underwent a low back fusion and decompression.

In February 1991, claimant returned to the employer's stock room where she worked at a modified job as a "marker." She worked 2 hours a day, 3 days a week. She sat on a stool and affixed prices to incoming cosmetics and was given the opportunity to walk and stand or sit at will. By July 1991, claimant's physicians permitted claimant to work 3 hours a day, 4 days a week. The employer did not immediately increase claimant's schedule at that time because the store was being refurbished and claimant's job as a marker was not available. (Ex. 63).

The employer placed claimant in a job where she was required to stand to unload freight 3 hours a day, 4 days a week. Dr. Sirounian, claimant's attending osteopath for her low back, concluded that she was not capable of being employed in other than a sedentary job with restrictions. (Ex. 64). In September 1991, claimant was released from work after developing pain in the low back, right leg, neck, arms and hands.

In February 1992, the employer reassigned claimant to her present job, Employee Entrance Watch Guard. Claimant sits on a stool near the entrance to ensure that only authorized persons enter the store. She checks vendors for proper identification, verifies entrance for those persons who are not on the vendors' list, has vendors sign a log, issues identification badges, and check persons out prior to the opening of the store. She can sit, stand or walk as desired. Claimant also sorts through out-of-place merchandise, placing the items in baskets to be returned to the proper area of the store by another person. Claimant works 3 hours a day, from 6 to 9 am, on Mondays, Tuesdays, Thursdays and Fridays. Claimant is paid $8.40 per hour for her work.

On April 14, 1992, claimant requested reconsideration of the permanent disability award, including permanent total disability.

An April 28, 1992 Order on Reconsideration increased claimant's unscheduled permanent disability to 46 percent and denied her request for permanent total disability.

Claimant is limited to working four days a week, three hours a day, and not more than two consecutive days in a row. She can occasionally carry 10 pounds, but is restricted from carrying anything over that weight. She is restricted from lifting from floor level. She may bend and twist occasionally. She is completely restricted from crawling, climbing, walking on rough ground, reaching above her shoulders, and working at heights. She can sit one hour, walk 10 to 20 minutes, and stand 15 minutes. She may use her arms for repetitive pushing and pulling, repetitive grasping, and can use her hands for repetitive fine manipulation. She must use a cane for safety, since her leg has a tendency to give way.

Claimant is released to less than the sedentary range of work.

Claimant graduated from high school. She can read and write. She has no skills using a cash register, typewriter or computer. She is somewhat hard of hearing.

The employer has a chain of stores in the Portland area. No other store has an employee who does the same job as claimant. Each store has a different method of admitting persons into the store before the general public is admitted. In some stores this is done by the nearest employee, in others by the person on duty at the customer service desk or the manager. On the days claimant does not work, employees at other work stations admit new arrivals. If claimant were not assigned to this job, the employer would use other employees to cover the door duty.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Tee v. Albertsons, Inc., 314 Or 633 (1992), concluded that claimant was not entitled to a permanent total disability (PTD) award, based on his finding that her current employment is "gainful." Claimant, in contrast, contends that Tee does not control, in that, even though she is presently employed, her present job is one created by this employer specifically to accommodate claimant and she cannot sell her services on a regular basis in a hypothetically normal labor market. In other words, claimant argues that the issue is her general employability, not whether her current part-time employment is "gainful."

Claimant must prove by a preponderance of the evidence that she is permanently totally

The issue here is whether claimant can "regularly perform work," i.e., can "sell [her] services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, supra. In Harris, the Supreme Court quoted with approval from Professor Larson:

> "The essence of the test is the probable dependability with which claimant can sell his services in a competitive labor market, undistorted by such factors as business booms, sympathy of a particular employer or friends, temporary good luck, or the superhuman efforts of the claimant to rise above his crippling handicaps."

Larson, 2 Workmen's Compensation Law, Section 57.51 (1976).

Claimant's job at the employer consists of the following. Prior to the opening of the store to the general public, claimant sits on a stool near the entrance to ensure that only authorized persons enter the store. She can sit, stand or walk as desired. She also sorts through out-of-place merchandise, placing the items in baskets to be returned to the proper area of the store by another person. Claimant works from 6 to 9 am, Monday, Tuesday, Thursday and Friday. Claimant contends that this is a job specially devised by the employer to accommodate her physical restrictions, and, as such, does not reflect her employability in the general labor market.

For an assessment of this job and claimant's employability, we turn to the reports and testimony of two certified vocational counselors, John Lipnicki and Adele Bostwick. Mr. Lipnicki concluded that claimant qualifies for the Preferred Workers program. He suggested that claimant could work at an answering service, telemarketing, light production work, or as a security guard. He also concluded that, if claimant were to become employable at other than the current employer, a short-term on-the-job training program would be needed to provide the financial incentive for an employer to work with her. He concluded his report by recommending that claimant remain in her current position until retirement. (Ex. 93-4). At hearing, he stated that the job claimant currently holds is similar to other part-time security work in which he has placed workers. He also testified that, like certain others of his disabled clients, claimant would be employable with the use of financial incentives, such as the Americans with Disabilities Act, target tax credits, and the Preferred Workers program.

Ms. Bostwick testified that the Dictionary of Occupational Titles had no job listed that included the same duties that claimant performed and that required the less than sedentary physical abilities to which claimant was limited. (Tr. 45-50). Ms. Bostwick also performed a survey of nine other local stores in the employer's chain and found that claimant's particular job does not exist at any other location; although someone lets people in prior to the store opening, it is done as a part of another employee's job. (Tr. 56). She opined that the job of "Greeter," which does exist at the employer and in the general economy, would be beyond claimant's physical capabilities, in that it requires constant standing and walking to greet customers and retrieve grocery carts.

Ms. Bostwick's findings about the employer's stores were verified by Mr. Ross, the general manager at the store at which claimant worked. In addition, he indicated that claimant's longevity at the store was also a consideration in her being assigned to the door opener job, in that she recognized most of the employees and vendors. (Tr. 103). Mr. Ross also indicated that claimant would not be eligible to perform the job of "Greeter," because a greeter is not permitted to sit when the store is open and must retrieve grocery carts.

Ms. Bostwick also opined that claimant's limited skills and physical capacity would prevent her from being approved for the Preferred Worker program. (Ex. 58). Furthermore, because claimant does not type and has no computer skills, she opined that claimant could not perform the alarm monitor or answering service operator jobs, which have become automated and require such skills. (Tr. 60). She also opined, based on her labor market survey and experience in placing people in security guard positions, that claimant did not have the physical capacity to perform that job. (Tr. 60 and Ex. 94). In addition, she concluded that claimant's age of 69 was a major factor in claimant's unemployability. (Tr. 60-61).

We are more persuaded by Ms. Bostwick's report and testimony than by Mr. Lipnicki's. Ms. Bostwick not only evaluated claimant's current job in light of the Dictionary of Occupational Titles, but also surveyed the other stores in the employer's chain and performed a labor market survey in formulating her conclusion that claimant is not employable in a competitive labor market. Furthermore, Mr. Lipnicki has not provided sufficient evidence that employers would be willing to hire claimant, even with the various financial incentives he specifies, given her age and physical limitations.

We conclude that the employer has provided claimant with a specialized position that was crafted to comply with her physical limitations. This part-time position, which was designed solely to accommodate claimant's physical limitations, is not a position generally available in a "normal" labor market. See Edna R. Ford, 42 Van Natta 45 (1990). Inasmuch as claimant's job is the result of something other than her ability to compete in the labor market, it is not evidence that she is, in fact, able to sell her services in the "normal" labor market. See 2 Larson, Workmen's Compensation Law, 57.35 (1987). Furthermore, even if claimant successfully performs as a sheltered employee entrance watch guard, we are not persuaded, on this record, that she is capable of regularly performing in a gainful and suitable occupation.

However, our inquiry does not end here. The employer argues that, because claimant is employed in a "suitable" occupation pursuant to ORS 656.206(1), she is barred from establishing PTD status if that suitable occupation is gainful. In Tee v. Albertson's, Inc., supra, the Supreme Court indicated that, where the question raised was whether a claimant was employable, Harris controls. Where the question is whether the occupation that claimant is deemed capable of performing is gainful, then Tee controls. In contrast to the case before us, the claimant in Tee was found to be "employable without training as a telemarketer and hotel/motel inspector" and that such work was available. Tee v. Albertson's, Inc., 314 Or at 636. We have concluded above that claimant is not employable in any suitable occupation. Consequently, it is not necessary for claimant to establish that her specialized position devised by the employer solely to accommodate her physical limitations is "gainful."

Consequently, because claimant is permanently incapacitated from regularly performing work in a gainful and suitable occupation, we conclude that she is permanently and totally disabled.

A permanent total disability award is effective as of the date the evidence establishes the disability status. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, modified 53 Or App 863 (1981). We conclude that the award of compensation for permanent total disability shall commence as of April 28, 1992. The insurer is authorized to offset any permanent partial disability compensation paid to claimant after that date against the permanent total disability award. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 32 (1983); Paul D. Rasmussen, 38 Van Natta 1310 (1986).

ORDER

The Referee's order dated March 9, 1993 is reversed. In lieu of the 46 percent (147.2 degrees) unscheduled permanent disability awarded by the Order on Reconsideration, claimant is granted permanent total disability, effective April 28, 1992. Claimant's attorney is assessed a fee equal to 25 percent of the increased disability compensation created by this order, payable by the insurer directly to claimant's attorney, not to exceed $6,000. The insurer is authorized to offset permanent partial disability compensation paid to claimant after April 28, 1992, if any, against claimant's permanent total disability award.

In the Matter of the Compensation of
LUCY E. BUCKALLEW, Claimant
WCB Case Nos. 92-02273 & 91-15725
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of those portions of Referee Holtan's order that: (1) upheld the insurer's denial of her current cervical arthritis condition; and (2) decreased her permanent disability award for the cervical condition from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to zero. In its brief, the insurer has moved to strike claimant's appellant's brief on the grounds that it was untimely filed. On review, the issues are compensability, extent of permanent disability and motion to strike.

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

Motion to Strike

The insurer has moved to strike claimant's appellant's brief, which was due on or before March 16, 1993, on the grounds that the brief was untimely filed. The insurer relies on the fact that the envelope containing the appellant's brief was postmarked March 18, 1993.

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." In this case, the certificate of service attached to the brief indicates that it was deposited in the mail on March 16, 1993. Thus, under the applicable administrative rule, claimant's appellant's brief was timely filed. Duane R. Paxton, 44 Van Natta 375, 376 (1992). Accordingly, the motion to strike is denied.

Compensability

The Referee found that claimant had not established compensability of her preexisting cervical arthritis under ORS 656.005(7)(a)(B). On review, claimant contends that the Referee applied the incorrect legal test, because he required claimant to establish that the compensable injury was the major contributing cause of her arthritic condition. Claimant argues that she need only establish that the compensable injury is the major contributing cause of her disability or need for treatment. Although we agree with claimant's statement of the law, we nevertheless agree with the Referee that the claim is not compensable.

ORS 656.005(7)(a)(B) provides that when a compensable injury combines with a preexisting disease or condition, the resultant condition is compensable only if the work-related injury is the major contributing cause of claimant's disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993) (Emphasis supplied); see also Angela Moon-Meyer, 45 Van Natta 1218 (1993).

Here, both Dr. Kauffman, claimant's attending physician, and Dr. Lewis, an orthopedic surgeon, indicate that claimant's compensable strain injury initially caused her previously asymptomatic degenerative condition to become symptomatic. However, both of these physicians have opined that the compensable strain injury has completely resolved and that the sole cause of claimant's current disability and need for treatment is the noncompensable degenerative condition.

In this regard, Dr. Kauffman opined that claimant's compensable strain injury had healed and that claimant's current symptoms were most likely due to her underlying degenerative disc disease. Dr. Lewis, who saw claimant on referral by Dr. Kauffman, also opined that claimant's compensable cervical strain injury had resolved and that her current symptoms and need for further treatment were secondary

We distinguish this case from U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). In Burtis, the medical evidence established that claimant's "resultant condition" was claimant's cervical strain superimposed on his degenerative cervical spine disease, and that the compensable injury was the major contributing cause of his disability and need for treatment. Here, by contrast, the medical evidence establishes that claimant's strain injury is no longer superimposed on her degenerative disc disease, but in fact, the strain has resolved, and claimant's symptoms now arise solely from her preexisting degenerative disc disease.

The opinions of Drs. Kauffman and Lewis to this effect are uncontroverted. Accordingly, we conclude that claimant's current disability and need for treatment are due solely to the preexisting noncompensable cervical arthritis. Inasmuch as the compensable injury is no longer the major contributing cause of claimant's disability and need for treatment, claimant has failed to establish compensability of her current cervical arthritis condition. See ORS 656.005(7)(a)(B).

ORDER

The Referee's order dated January 12, 1993 is affirmed.

January 24, 1994 Cite as 46 Van Natta 116 (1994)

In the Matter of the Compensation of
WALTER E. FRAIDENBURG, Claimant
WCB Case No. C3-03181
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
W. Todd Westmoreland, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Member Neidig and Hall.

On December 10, 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 agreement.

Here, the proposed agreement provided "[t]he accepted conditions which are the subject of this disposition are all compensable conditions arising out of the injurious exposure . . . and including the following: right elbow contusion/lateral humeral epicondylitis. Such conditions may be limited by other proceedings on this claim. This disposition does not limit reasonable and necessary medical treatment related to such compensable conditions attributable to this claim."

On December 15, 1993, we requested that the parties submit an addendum clarifying the abovementioned language. The parties then submitted an addendum which clarified the accepted condition, but language concerning "limitation of the condition" and "reasonable unnecessary [sic] medical treatment" remains in the CDA.

We have previously held that a CDA may dispose of only accepted conditions. See Frederick M. Peterson, 43 Van Natta 1069 (1991). Thus, the language stating that the accepted condition(s) may be limited by other proceedings could be construed to refer to a denial. Finally, the Board has previously held that language referring to "reasonable and necessary" medical services could be interpreted to limit a claimant's right to medical services. See Kenneth D. McDonald, 42 Van Natta 2307 (1990). Under the circumstances, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2)(b). 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 dispositions. See OAR 436-60-150(4)(i) and (6)(e).

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

In the Matter of the Compensation of
ROBERT P. HOLLOWAY, SR., Claimant
WCB Case No. 92-05993
ORDER ON RECONSIDERATION
Tooze, Shenker, et al., Claimant Attorneys
William E. Brickey, Defense Attorney

On November 16, 1993, we withdrew our October 18, 1993 Order on Review that: (1) set aside SAIF's "de facto" denial of claimant's claim for home health care; (2) awarded an assessed attorney fee of $3,250 for services at hearing and on review for prevailing over the "de facto" denial; and (3) awarded an assessed attorney fee of $750 for SAIF's unreasonable resistance to the payment of compensation under ORS 656.382(1). We took this action to consider SAIF's motion for reconsideration, and to allow claimant an opportunity to respond to SAIF's motion. Having received claimant's response, we proceed with our reconsideration.

On reconsideration, SAIF specifically requests that the Board find that: (1) there was no "de facto" denial of home health care, or in the alternative, that the issue of home health care was rendered moot at the time of hearing; and (2) claimant's attorney is not entitled to attorney fees under either ORS 656.386(1) or 656.382(1). In his response, claimant requests that in the event we decline to award an assessed attorney fee pursuant to ORS 656.386(1), we award a $4,000 attorney on the basis of ORS 656.382(1) alone.

"De facto" denial

SAIF argues that there was no "de facto" denial because claimant never submitted a claim for medical services which SAIF was required to process. SAIF's argument takes two forms.

Relying on claimant's June 20, 1991 letter wherein he states "I would hope to only need this form of care for only 8 weeks hopefully," SAIF calculates that claimant's need for treatment would have ended approximately September 6, 1991 just prior to the expiration of SAIF's statutory 90 day claim processing time on September 18, 1991 (Ex. 65). See ORS 656.262(6). Reasoning that since the need for home health care had passed by the time of the claim processing deadline, SAIF argues there was no "de facto" denial.

Said somewhat differently, SAIF further contends that because friends, as opposed to medical providers, assisted claimant with home health care there was no medical bill submitted to SAIF for processing. Accordingly, SAIF concludes there was no "claim" for medical services, and thus, nothing to accept or deny. That being the case, SAIF reasons that there could be no "de facto" denial.

To begin, it is not clear that claimant's home health care was only 8 weeks in duration. The medical record, as opposed to claimant's personal opinion quoted above, does not indicate the duration of the home health care. We do not have the benefit of Dr. Butters' opinion on this matter. Moreover, claimant did not testify how long the home health care actually lasted. (Tr. 13). Based on this record, we find claimant's statement that home health care would have lasted 8 weeks speculative.

In any event, the duration of claimant's need for home health care is irrelevant. The record shows that claimant submitted to SAIF a written request for home health care dated June 20, 1991. (Ex. 65). Attached to this request was a June 17, 1991 letter from his attending surgeon and physician, Dr. Butters, which indicated that claimant would need home health care services following the July 9, 1991 surgery. (Ex. 46). This request was received by SAIF on June 24, 1991. (Tr. 19-20, Ex. 59). It is clear from Dr. Butters' discharge note following surgery that he was under the impression that claimant would receive this care. (Ex. 47C).

ORS 656.262(6) allows an insurer 90 days in which to accept or deny a claim after it has notice or knowledge of the claim. A "claim" is a written request for compensation, including a request for medical payment, from a subject worker or someone on the worker's behalf. ORS 656.005(6) &(8); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Such a request does not have to take any particular form. For example, a doctor's chart notes or bill submitted to an insurer is a claim. Billie J. Eubanks, 35 Van Natta 131 (1983).

We find claimant's June 20, 1991 letter requesting home health care pursuant to his doctor's instructions and accompanied by the doctor's letter expressing the need for such care is a claim for medical services. ORS 656.005(6). Therefore, upon notice or knowledge of the claim SAIF was required to accept or deny within 90 days. The testimony of the SAIF's claim examiner and nurse consultant show that SAIF had knowledge of the claim, and, in fact, proceeded to process the claim. The claims examiner referred the matter to a SAIF nurse consultant. (Tr. 25-27). The nurse consultant then made an assessment of claimant's need for home health care and concluded that it was not appropriate. It was for this reason the claim was not accepted. (Tr. 67-70). Yet, despite this decision, SAIF declined to take the next step of either seeking Director review or notifying claimant of the denied services by issuing a formal denial of the claim.

Inasmuch as SAIF failed to respond to claimant's home health care claim within 90 days of its knowledge of the claim, we find that claimant has established a "de facto" denial of medical services. Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992); Barr v. EBI Companies, 88 Or App 132, 134 (1987).

"Mootness" Argument

In the alternative, SAIF argues that because claimant's need for home health care no longer existed at the time of hearing, the issue was moot citing Sherry A. Young, 45 Van Natta 2331 (1993).

A case is "moot" when a determination is sought on a matter which, when rendered, cannot have any practical effect on the existing controversy. Black's Law Dictionary 909 (5th ed. 1979).

Although it is likely that at the time of hearing claimant no longer needed home health care that finding does not resolve the controversy. Still at issue was entitlement to an assessed fee for prevailing over a denial of compensation, and entitlement to either a penalty or an assessed fee for an unreasonable resistance to the payment of compensation. Resolution of these issues required a determination of the compensability of home health care. Thus, there remained a justiciable controversy for the Hearing Division to resolve.

Moreover, we find this case distinguishable from Sherry A. Young. The issue in Young was review of a Director's "327" order which had found inappropriate claimant's request for low back surgery. In our order we concluded the issue was moot. In so holding, we noted that subsequent to the Director's order, the carrier had submitted a second surgery request to the Director. Based on new evidence the Director had issued a second order, this time finding the surgery appropriate. The second order became final and the surgery was performed.

Based on these facts, we concluded that the second order finding the proposed surgery appropriate in conjunction with ensuing events, (no appeal from that order, performance of the surgery, payment of surgery by the carrier, and the parties' acknowledgment that further surgery would not result from our decision) rendered the issue before us moot. In other words, because the claimant's second surgery request had been satisfied in all respects, a decision by us regarding whether or not the claimant's first surgery request was appropriate or inappropriate would have had no meaningful effect because, regardless of our decision, no additional surgery would be performed. Sherry A. Young, supra.

In contrast, here, there is only one request for medical services, and this claim has yet to be satisfied. As previously discussed, claimant's attending physician requested professional home health care be provided after claimant's surgery. Despite this request, the care was neither authorized nor paid by SAIF. Nor did SAIF pay for the "volunteer" friends who actually provided the needed services. Finally, the reasonableness of SAIF's conduct and the ramifications from such a finding are contingent on the compensability of claimant's home health care claim. Although claimant may have failed to prove the existence of a medical bill for professional services because he relied on friends for assistance, this does not mean the dispute in this case has been rendered moot. Accordingly, we are persuaded that there remains a justiciable controversy for our resolution.

Attorney fees under ORS 656.386(1)

SAIF argues that even assuming claimant has prevailed over a denial of compensability, claimant is not entitled to an assessed attorney fee under ORS 656.386(1) relying on SAIF v. Allen, 124 Or App 183 (1993). Subsequent to our order on review, the court issued its decision in SAIF v. Allen.

In Allen, the claimant had sustained a compensable injury. SAIF, as the responsible insurer paid some medical bills, but not all. The claimant requested hearing on the unpaid bills. Just prior to hearing SAIF paid the bills and the parties agreed that the claimant was entitled to penalties and attorney fees. ORS 656.262(10); 656.382(1). Thus, the sole issue at hearing was attorney fees under ORS 656.386(1). The Board, affirming the Referee, held that the claimant's counsel was instrumental in obtaining compensation for the claimant without a hearing, and on that basis awarded fees pursuant to ORS 656.386(1). The court reversed.

Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." The court noted that the compensability of the claimant's injury was not disputed. Rather, claimant sought a hearing regarding nonpayment of some medical bills. Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute." Because the hearing in Allen pertained to nonpayment of medical bills and because compensability was never disputed, the claimant's attorney was not entitled to an award of fees under ORS 656.386(1).

In the present case, the dispute pertains to medical services for an accepted claim. There is no evidence in the record indicating there was a dispute concerning whether or not the home health care was causally related to claimant's compensable injury. Rather, the evidence establishes that the medical services at issue were "de facto" denied on the basis that said services were not reasonable or necessary.

Based on the court holding in Allen, an attorney fee may not be awarded under ORS 656.386(1) since the subject of the hearing was not a dispute about the "compensability" of claimant's injuries. See SAIF v. Allen, supra; see also Caroline F. Wood, 45 Van Natta 2223 (1993). Therefore, that portion of our prior order which awarded claimant's counsel $3,250 under ORS 656.386(1) is vacated.

Attorney fee under ORS 656.382(1)

Finally, we continue to conclude that by failing to process the claim SAIF unreasonably resisted the payment of compensation, thereby entitling claimant to an attorney fee under ORS 656.382(1). By failing to formally respond to the claim, SAIF placed claimant in a "holding pattern" thereby delaying the process and ultimate resolution of the claim as to the compensability issue. SAIF's nonaction had the effect of "denied" benefits. We find this failure to formally respond to the claim unreasonable.

On reconsideration, claimant requests that in the event we decline to award an assessed attorney fee pursuant to ORS 656.386(1), we award an attorney fee pursuant to ORS 656.382(1) in the amount of $4,000. We consider claimant's request.

In our prior order we awarded claimant's counsel what we deemed to be a reasonable assessed fee of $750 for SAIF's unreasonable resistance to the payment of compensation. In doing so, although not expressly articulated in our determination, we took into consideration the fact we had awarded claimant a $3,250 fee under ORS 656.386(1). Because we have decided to vacate that portion of our prior order, we likewise reconsider the fee awarded under ORS 656.382(1).

In determining a reasonable attorney fee under ORS 656.382(1), we consider the factors recited in OAR 438-15-010(4). Those factors are as follows: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (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 considering the above factors and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the unreasonable claim processing issue is $2,500, to be paid by SAIF. In so holding, in addition to the factors noted in our prior order, we have particularly considered the risk that claimant's counsel might go uncompensated and the assertion of a frivolous issue or defense, i.e., SAIF's assertions that there existed "no claim" to process and/or that the unanswered claim subsequently became moot as a result of claimant's friends' volunteer efforts.

Finally, we note claimant has submitted a statement of services which reflects a fee amount of $2,500 for services on the issue of "De facto denial, or improper processing, of claim for home health care services." Although claimant has subsequently requested a fee in excess of this amount, we note the court has held that it is an abuse of discretion by the Board to award an attorney fee greater than that actually claimed by claimant's attorney. See SAIF v. Severson, 105 Or App 67 (1990).

Therefore, based on the foregoing reasoning, we find a reasonable assessed fee on this issue is $2,500. In lieu of that portion of our order which awarded claimant's counsel $750 for SAIF's unreasonable resistance to the payment of compensation under ORS 656.382(1), claimant's counsel is awarded an assessed fee of $2,500.

Accordingly, on reconsideration, as modified and supplemented herein, we adhere to our October 18, 1993 order. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM U. ROSENTHAL, Claimant
WCB Case No. C3-03293
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gary D. Taylor, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Member Neidig and Hall.

On December 22, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

The CDA provided in part, that certain permanent disability benefits had been awarded, that "ha[d] been paid or will be paid." It further provided that the total proceeds of the CDA would be $2,400.

On January 18, 1994, the parties submitted an addendum to the agreement. The amended CDA eliminated the above-quoted language concerning the payment of permanent disability benefits, and provided that the lump sum payment to claimant had been increased from $2,400 to $11,269.73, in exchange for claimant's release of rights to temporary disability; past, present, and future permanent disability; vocational rehabilitation; survivor's benefits; own motion rights and aggravation rights. (Emphasis added). The payment to claimant had been increased to include amounts previously awarded for permanent partial disability that had not yet been paid at the time the CDA was submitted to the Board. See Kevin E. Sahlfeld, 45 Van Natta 1779 (1993).

In Sahlfeld, the parties' proposed agreement provided that the remaining unpaid balance of the claimant's permanent disability award would be accelerated and paid along with the CDA. We disapproved the disposition, reasoning that we were not authorized to permit such an action because the acceleration of permanent disability awards is an action which is expressly within the Director's discretion. ORS 656.230; Erven Simril, 43 Van Natta 629 (1991). Sahlfeld, supra. The Sahlfeld order further provided comments to assist the parties to eventually achieve their objective in a manner that was in compliance with Board authority. The CDA in the instance case is in compliance with the comments provided in Sahlfeld.

We have previously held that, where the parties' revision of a proposed agreement substantially alters the amount of consideration underlying the bargain, the modified agreement constitutes a new CDA. In such cases, the claimant's statutory 30 days to request disapproval is reimplemented, beginning from the date the revised CDA is acknowledged. Mary A. Smith, 45 Van Natta 1072 (1993).

We find the present case to be distinguishable from Smith, supra. In Smith, the revised agreement provided for less consideration than the original agreement. Consequently, we treated the revised agreement as a new submission. However, in cases where the revised agreement results in a "redistribution" of funds and an additional recovery to the claimant, we have found that the revised agreement may be approved without a resubmission of the CDA. Richard R. Millus, 45 Van Natta 810 (1993).

In the present case, the parties' amended agreement actually provides claimant with additional consideration by including the amount of unpaid permanent disability benefits in exchange for claimant's release to all past, present and future awards. Therefore, we see no reason to require another 30 day waiting period as provided by ORS 656.236(1)(c). Furthermore, the parties' amended agreement complies with Sahlfeld, supra.

Under the circumstances, we find that the amended agreement actually provides claimant with additional consideration. Therefore, consistent with Millus, supra, we find no reason to treat the amended agreement as a new CDA, or to require resubmission and reacknowledgment of the agreement.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $600, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIOLA SLOVER, Claimant
WCB Case No. C4-00095
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Burt, Swanson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Member Neidig and Hall.

On January 11, 1994, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed agreement.

A claim disposition agreement must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). An agreement is "unreasonable as a matter of law" if it exceeds the bounds of applicable administrative rules, or if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). OAR 436-60-145(3)(j) and OAR 438-09-020(1)(a) require that an agreement provide the amount of consideration to be paid claimant for her release of benefits.

Here, the agreement provides that no consideration will be paid claimant under this current CDA (August 2, 1992 injury) but, rather, that claimant's consideration for this CDA was paid in conjunction with CDA No. C3-03025 (June 18, 1988 injury), which was previously approved by the Board on December 23, 1993.

We have previously held that a CDA which does not provide for a separate amount of consideration for each claim exceeds the bounds of the rules. See OAR 436-60-145(3)(j); 438-09-020(1)(a); Jerry H. Foss, 43 Van Natta 48 (1991). In Foss, we disapproved a CDA that consisted of two separate claims providing that the amount of consideration for the claimant's release was $10,000, to be paid under one claim, and that "other consideration" would be paid under the second claim. "Other consideration" was not identified.

Furthermore, in this case, by asserting that claimant's consideration for the current CDA was paid under a prior CDA, the parties are, in essence, attempting to amend a previously approved CDA. A CDA, however, once it becomes final, is an order that may not be amended or appealed. ORS 656.236(2). Consequently, for the abovementioned reasons, we find that the CDA is "unreasonable as a matter of law." ORS 656.236(1)(a).

Finally, because the amount under the prior CDA has already been paid to claimant, we find that, under such circumstances, any proffered consideration for this CDA which attempts to use past consideration is "illusory."

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

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

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

IT IS SO ORDERED.

January 25, 1994 Cite as 46 Van Natta 122 (1994)

In the Matter of the Compensation of
GARY L. HARRIS, Claimant
WCB Case Nos. 91-09781 & 90-22646
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Pamela A. Schultz, Defense Attorney
Lundeen, et al., Defense Attorneys

Claimant requests reconsideration of our December 28, 1993 Order on Review which: (1) found that Liberty Northwest Insurance Corporation, on behalf of Bill Gurlock Towing, was responsible for claimant's occupational disease claim for bilateral hearing loss; and (2) awarded claimant's counsel an assessed fee of $3,300 for services rendered at hearing and on review. Claimant contends that his counsel's assessed fee should be increased to $4,250. We modify the award.

After reconsidering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that an assessed fee award of $3,300 does not adequately compensate claimant's counsel for his services at hearing and on review concerning the compensability issue. In particular, we find that the compensability of claimant's bilateral hearing loss was a complex issue involving injury and occupational disease claims against two employers. We also find that claimant's counsel expended considerable efforts in securing for his client substantial benefits for an initial claim. Claimant's counsel participated in a four-hour hearing involving extensive cross-examination of Liberty's witnesses. Moreover, we note that Liberty did not object to the total amount of the Referee's $3,000 assessed fee award for claimant's counsel's services at hearing.

Based on our reconsideration of the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,650, to be paid by Liberty, on behalf of Bill Gurlock Towing. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have also considered the fact that, whereas claimant's counsel asserted on review that the Referee's injury analysis should be "affirmed in its entirety," we reversed that analysis and, instead, analyzed the hearing loss claim as an occupational disease.

Accordingly, we withdraw our December 28, 1993 order. On reconsideration, as modified herein, we adhere to and republish our December 28, 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
BRUCE L. HIRSCHKORN, Claimant
WCB Case No. 90-20179
ORDER ON REMAND
Vick & Gutzler, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Hirschkorn, 117 Or App 542 (1992). The court reversed our prior order, Bruce L. Hirschkorn, 43 Van Natta 2535 (1991), which set aside the SAIF Corporation's denial of claimant's right knee injury claim, but upheld its denial of claimant's current "resultant" condition. Citing Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" and "Ultimate Findings of Fact" contained in our November 19, 1991 order.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's work activities on July 13, 1990 were a material contributing cause of his need for medical treatment, the Referee concluded that claimant had sustained a compensable right knee injury. Consequently, the Referee set aside SAIF's denial. In reaching this conclusion, the Referee acknowledged SAIF's contention that the claim was not compensable because claimant's right knee sprain had combined with his preexisting right knee arthritic condition and that the sprain was not the major contributing cause of the resultant condition. See ORS 656.005(7)(a)(B). Nevertheless, reasoning that the only relevant issue for determination was whether claimant had suffered an accidental injury while performing his work activities, the Referee declined to address SAIF's "resultant condition" argument.

In our prior order, we agreed with the Referee's findings that claimant's July 13, 1990 work activities were a material contributing cause of his right knee sprain injury and, thus, the injury claim was compensable. Bruce L. Hirschkorn, supra. However, based on the opinion of Dr. Gripekoven (claimant's treating orthopedist), we further found that the compensable injury combined with claimant's preexisting arthritic condition and that the major contributing cause of the resultant condition was the preexisting condition. Inasmuch as claimant's work injury was not the major contributing cause of his resultant condition, we upheld SAIF's denial insofar as it denied claimant's resultant disability and need for medical treatment. We relied on the reasoning expressed in Bahman N. Nazari, 43 Van Natta 2368 (1991).

Subsequent to our order, the court reversed our decision in Nazari. Interpreting ORS 656.005(7)(a)(B), the court reasoned as follows:

> "If, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an initial claim, the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment." Tektronix, Inc. v. Nazari, on recon at 594.

Citing Nazari, supra, the court has reversed our prior order and remanded for reconsideration.

Here, Dr. Gripekoven concluded that claimant experienced an overuse type of knee sprain which was superimposed on a preexisting post-traumatic condition. (Ex. 5). Dr. Gripekoven identified claimant's preexisting condition as the major contributing factor for claimant's present knee problem. Id. This opinion is uncontradicted.

In light of such circumstances, we are unable to conclude that claimant's disability or need for medical treatment were due to the July 13, 1990 work injury alone. Rather, the record establishes that claimant's disability and need for treatment for his right knee condition resulted from a combination of the work injury and a preexisting condition. Thus, in order to establish compensability of his claim, claimant bears the burden of proving that the work injury was the major contributing cause of his resultant condition. See Nazari, supra. Based on Dr. Gripekoven's uncontradicted and persuasive opinion, claimant has not satisfied this statutory requirement. See ORS 656.005(7)(a)(B); Tektronix v. Nazari, supra. Consequently, SAIF's denial must be upheld in its entirety.

Accordingly, on reconsideration, we reverse the Referee's order dated February 28, 1991.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

Board Member Gunn is bound by stare decisis to follow the court's holding in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). But, this case like many, troubles me because at what point does the claimant's traumatized, arthritic knee predispose him to the injury? The medical evidence is that if this claimant had a "normal" knee, his condition, "overuse strain," would never have arisen. I am not sure what constitutes a "normal" knee. At my age (40+) and after a short stint in the Marine Corp, I suspect my knee is not "normal." I also suspect if I attempted the work claimant performed, my knee would swell up. The last I looked, the purpose of workers' compensation was to pay medical bills and disability for problems arising from work. The court would now require that the workers' bodies be "normal" before any injury or disability could be covered by workers' compensation. I suspect the court, without explicitly saying so, has eliminated the principle that the employer takes the worker as they find them.

In the Matter of the Compensation of
LINDA K. MISNER-WERTZ, Claimant
Own Motion No. 93-0085M
OWN MOTION ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant requested reconsideration of our September 21, 1993 Own Motion Order in which we declined to reopen her claim for own motion relief on the ground that she had not established that she was in the work force at the time of her April 28, 1989 disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our September 21, 1993 order and granted the insurer an opportunity to respond to the motion. With its response, the insurer raised a new issue in that it disagreed with our decision that the surgical removal of the tibial screws from claimant's knees was curative treatment. We granted claimant an opportunity to respond to this new issue raised by the insurer. We have received claimant's response and proceed with our reconsideration.

As to the insurer's argument that the bilateral surgical removal of the tibial screws from claimant's knees was not curative treatment, that argument was adequately addressed in our initial Own Motion Order. In this regard, although Dr. Boyd, claimant's treating surgeon, did not explicitly state that the surgical removal of the tibial screws from claimant's knees was curative treatment, we find that his reports as a whole establish that that treatment was curative. (Exs. 39, 41, 43, 44). In reaching this conclusion, we note that the use of "magic words" or statutory language is not required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992), as cited in U Haul of Oregon v. Burtis, 120 Or App 353 (1993); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986. Thus, we continue to conclude that claimant's surgery was curative treatment.

As to the work force issue, we continue to conclude that claimant has not established that she was in the work force at the time of her disability. As we found in our initial order, claimant's compensable bilateral knee condition worsened requiring surgery as of April 28, 1989, which is the time of disability. Therefore, claimant must prove that she was in the work force as of that date. 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 employment; or (3) not working but willing to work, although not making reasonable efforts to obtain employment 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.

On June 6, 1989, in response to an inquiry from the insurer, claimant stated that she last worked in November 1979 and had not worked since leaving that employer. (Ex. 41A). It is that statement upon which we based our conclusion in our initial order that claimant was not in the work force when her condition worsened in April 1989.

With her request for reconsideration, claimant submitted an October 12, 1993 affidavit as evidence that she was in the work force when her condition worsened. Claimant does not argue and the record does not support that the work injury made reasonable efforts to find employment futile. Instead, claimant stated that, prior to her surgery, which was performed on October 18, 1989, she was "available for work, willing to work, and seeking to return to work in a position within [her] physical and vocational limitations."

Claimant also stated that she performed the following voluntary work: (1) she worked as a volunteer for Memorial Elementary School from about September 1988 until shortly before her surgery; (2) she volunteered her time at Mac Rental Corporation during 1988 and 1989; and (3) she performed secretarial and bookkeeping duties for Mid-Oregon Rental Association on a volunteer basis during 1988 and 1989.

This voluntary work is not gainful employment. Danell L. Sweisberger, 44 Van Natta 913 (1992). In addition, ORS 656.005(28) defines a "worker," in part, as a person "who engages to furnish services for a remuneration." There is no evidence that claimant was paid for her voluntary services.

Regarding her work search efforts during 1988 and 1989, claimant made the following statements. Claimant stated that she volunteered at the school, in part, to stay informed about possible openings for paid positions and inquired about the availability of such positions. She stated that she made numerous inquiries about possible openings with Mac Rental Corporation during 1988 and 1989. She also stated that she volunteered with the Mid-Oregon Rental Association to maintain her clerical skills and to assist her husband who was the association's president. Claimant stated that she received payment for babysitting and sometimes provided babysitting services in return for like services from friends. Finally, claimant stated that she regularly reviewed newspaper classified ads but was unable to find suitable employment.

We do not find that the above statements establish a reasonable job search. Although admittedly able to perform clerical services on a volunteer basis, claimant only made inquiries at two places regarding potential employment. Claimant submits no information regarding any payments for babysitting services and bartering for like services does not constitute gainful employment. Finally, "reviewing" classified ads, without more, does not establish a reasonable job search.

Here, claimant stated that she had not been employed since 1979, we do not find that claimant's voluntary services establish that she returned to the work force. Furthermore, claimant has not established a reasonable job search that would prove that she was in the work force at the time of her disability.

Accordingly, our September 21, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 21, 1993 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH E. RICKARD, Claimant
WCB Case No. 91-06676
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Rickard v. Calista Corp., 124 Or App 208 (1993). The court has reversed that portion of our prior order which held that the Hearings Division lacked jurisdiction to consider disputes concerning claimant's proposed surgery and accompanying aggravation claim. Citing Jefferson v. Sam's Cafe, 123 Or App 464 (October 6, 1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue in this claim concerns claimant's request for authorization of proposed low back surgery. Claimant had also filed an aggravation claim based on the request for surgery. The insurer denied both the medical services and aggravation claims on May 24, 1991.

The Referee dismissed claimant's request for hearing regarding the insurer's denial of his medical services claim for lack of jurisdiction. The Referee also declined to address the merits of the aggravation claim, pending resolution of the medical services claim.

We affirmed the Referee's order, citing Kevin S. Keller, 44 Van Natta 225 (1992) and Gary L. Waldrupe, 44 Van Natta 702 (1992). Subsequent to our order, the court has held that jurisdiction over medical services disputes involving proposed medical treatment now resides in the Hearings Division. Jefferson v. Sam's Cafe, supra. Relying on Jefferson, the court has reversed and remanded for reconsideration of the medical treatment and aggravation claims. Accordingly, we proceed with our reconsideration.

There are two medical opinions that are relevant to the surgery issue. In October 1989, Dr. Smith, the attending physician and surgeon, had previously requested and obtained the insurer's authorization for surgery. Claimant, however, decided to undergo further conservative treatment before agreeing to surgery. Dr. Smith then withdrew his request for authorization of surgery.

In March 1991, after claimant's low back condition failed to improve, Dr. Smith renewed his request for surgery. Dr. Smith noted that claimant's condition had continued to deteriorate despite a lengthy course of conservative care. Dr. Smith emphasized that the condition for which he had previously sought and received authorization for surgery was still present.

Dr. Raaf, the examining physician, opined that claimant's history and physical findings were incompatible with a protruded lumbar intervertebral disc. Concluding that surgery was not indicated, Dr. Raaf recommended further conservative treatment.

When the medical evidence is divided, we generally give greater weight to the treating physician's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no such reasons.

As the attending physician since 1989, Dr. Smith has had the opportunity to follow the course of claimant's low back condition for an extended period of time. Considering this extensive familiarity with claimant's low back condition, we consider Dr. Smith's observations to be more persuasive than those offered by Dr. Raaf. In addition, Dr. Raaf provides little or no explanation why surgery is not indicated. Likewise, Dr. Raaf does not address the question of why additional conservative treatment should be administered when claimant had already undergone an extensive period of such treatment with no success. In light of such circumstances, we find Dr. Raaf's opinion to be conclusory and unpersuasive. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Finding no persuasive reason not to rely on the opinion of Dr. Smith, we conclude that claimant's low back surgery claim is compensable. Since the aggravation claim is expressly contingent on the surgery claim, we also conclude that claimant's compensable condition has worsened since the last arrangement of compensation. See ORS 656.273(1). Consequently, the aggravation claim is also compensable.

On reconsideration of our August 27, 1992 order, we set aside the insurer's denial of claimant's low back surgery and aggravation claims. Those claims are remanded to the insurer for processing in accordance with law.

IT IS SO ORDERED.

January 25, 1994 Cite as 46 Van Natta 127 (1994)

In the Matter of the Compensation of
HOWARD R. SENEY, Claimant
WCB Case No. 90-10386
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993). The court reversed our prior order which set aside the self-insured employer's denial of claimant's "new injury" claim for a left shoulder condition. In reaching our conclusion, we had concluded that a prior stipulation concerning claimant's appeal from a Determination Order did not preclude his subsequent "new injury" claim for his left shoulder condition. Reasoning that claimant's left shoulder condition and the compensability of a potential claim (regardless of whether characterized as an aggravation or "new injury" claim) were at issue during the negotiations and before approval of the stipulation, the court has held that claimant cannot escape his bargain by recharacterizing his claim from an aggravation claim to a "new injury" claim after the fact. Consequently, the court has remanded for reconsideration.

In light of the court's holding, we conclude that claimant's "new injury" claim for his left shoulder condition is barred by the prior stipulation. Consequently, we reinstate and uphold the self-insured employer's denial of claimant's "new injury" claim.

Accordingly, on reconsideration of our January 17, 1992 order, the Referee's order dated February 25, 1991 is reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID J. BUNK, Claimant
WCB Case Nos. 92-03345 & 92-02314
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of those portions of Referee Barber's order that: (1) affirmed an Order on Reconsideration award of 4 percent (6 degrees) scheduled permanent disability for a left leg condition; (2) awarded 10 percent (32 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration awarded no unscheduled permanent disability; and (3) declined to award penalties and attorney fees pursuant to ORS 656.268(4)(g) and ORS 656.382(1). On review, the issues are extent of scheduled and unscheduled permanent disability and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Order on Reconsideration award of 4 percent (6 degrees) scheduled permanent disability for the left leg. In addition the Referee awarded 10 percent unscheduled permanent disability and declined to assess a penalty pursuant to ORS 656.268(4)(g).

Evidence

In January 1992, Dr. Slack examined claimant and filled out a questionnaire (Ex. 12b) concerning the extent of claimant's scheduled and unscheduled permanent disability. The examination and report were completed approximately six months after the August 7, 1991 Notice of Closure, but prior to the February 12, 1992 Order on Reconsideration and the March 5, 1992 corrected Order on Reconsideration.

Dr. Slack is not claimant's attending physician; however, Dr. Hacker, claimant's attending physician, concurred with Dr. Slack's impairment findings. Accordingly, the limitations contained in ORS 656.245(3)(b)(B) do not apply and Dr. Slack's findings (with which Dr. Hacker concurred) may be used to assign impairment values under the standards. See Gary C. Fischer, 46 Van Natta 60 (1994); Timothy J. Smith, 44 Van Natta 2246 (1992).

We note that Dr. Slack's report (Ex. 12b), although post-closure, was properly admitted by the Referee. ORS 656.268(5) limits the evidence that may be submitted on reconsideration before the Department to evidence which corrects erroneous information in the record and to medical evidence that should have been but was not submitted at the time of claim closure. However, the court has recently held that ORS 656.268(5) limits the evidence that may be submitted on reconsideration before the Department, but does not limit the evidence that may be submitted at a hearing before a referee. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993); Cynthia L. Luciani, 45 Van Natta 1734 (1993).

While there are other statutory limitations on evidence that may be presented at hearing (ORS 656.245(3)(b)(B); 656.268(7); 656.283(7)), none of those limitations is applicable here. (We have specifically held above that the limitation contained in ORS 656.245(3)(b)(B) does not apply since the attending physician concurred in Dr. Slack's impairment findings).

Under these circumstances, Dr. Slack's findings were properly admitted and considered in determining the extent of claimant's permanent disability. Cynthia L. Luciani, supra.

Premature Closure

In his brief, claimant asserts that he was not medically stationary at the time of closure. Our review is limited to the issues raised at hearing. Here, the record reveals that the issues raised at hearing were the extent of scheduled and unscheduled disability, offset, and penalties and attorney fees. (Tr. 1-2). Inasmuch as the premature closure issue was not raised before the Referee, we will not consider it on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Extent of Permanent Disability

In rating the extent of claimant's permanent disability, we apply the disability rating standards in effect on the date of the August 7, 1991 Notice of Closure. OAR 438-10-010, 436-35-003(2). The applicable standards are those contained in WCD Admin. Order 2-1991.

Scheduled Disability

The Referee found Dr. Slack's impairment findings unpersuasive on the basis that Dr. Slack did not treat claimant and only examined him once. The Referee likewise found Dr. Hacker's concurrence with Dr. Slack's findings unpersuasive on the basis that Dr. Hacker did not give an explanation as to why he changed his opinion between his closing report in October 1991 and his concurrence with Dr. Slack in January 1992. The Referee concluded that the only persuasive evidence of scheduled impairment was contained in Dr. Hacker's October 1991 closing report. We disagree.

In his October 25, 1991 letter, Dr. Hacker explained that the scope of the report which claimant's attorney had requested from him concerning claimant's impairment was "beyond the facilities" of his office. (Ex. 12). In the same letter, Dr. Hacker suggested an independent medical evaluation to rate claimant's impairment if Dr. Hacker's findings were insufficient. Claimant was evaluated by Dr. Slack in January 1992. Although Dr. Slack examined claimant only once for the purpose of rating claimant's permanent disability, Dr. Slack's findings were concurred in by Dr. Hacker who was familiar with claimant's condition. We do not interpret Dr. Hacker's concurrence with Dr. Slack's report as a change of opinion regarding claimant's impairment from his earlier report. Dr. Hacker had previously explained that his office lacked the facilities to perform the evaluation which was requested. Under the circumstances, we consider Dr. Slack's impairment findings for the purposes of rating claimant's permanent impairment.

Based on Dr. Slack's January 7, 1992 findings, claimant has 4/5 strength of the S-1 nerve root. The maximum loss of function due to loss of strength in the S-1 nerve root is 20 percent of the leg. Former OAR 436-35-230(7). A 4/5 grade of strength is 20 percent. Former OAR 436-35-007(14). Claimant's impairment due to loss of strength in the S-1 nerve root is 4 percent (20 percent multiplied by 20 percent). Former OAR 436-35-230(7) and former OAR 436-35-007(14). Claimant has 4/5 strength of the sciatic nerve. The maximum award for an injury to the sciatic nerve is 75 percent. Thus, claimant is entitled to 15 percent impairment for an injury to the sciatic nerve (20 percent multiplied by 75 percent). Former OAR 436-35-230(8) and former OAR 436-35-007(14). According to Dr. Slack, claimant is unable to repetitively use his left leg due to a chronic and permanent medical condition. Therefore, claimant is entitled to an award of 5 percent. Former OAR 436-35-010(6).

Based on Dr. Slack's findings, claimant has 4/5 strength in the common peroneal nerve. The maximum award for injury to that nerve is 39 percent. Thus, claimant is entitled to an award of 8 percent (20 percent multiplied by 39 percent equals 7.8 percent which is rounded to 8 percent). Former OAR 436-35-230(8); former OAR 436-35-007(14) and former OAR 436-35-007(11).

Claimant has 4/5 strength in the common peroneal nerve (deep - below mid shin). The maximum award for injury to that nerve is 6 percent. Thus, claimant is entitled to an award of 1 percent (20 percent multiplied by 28 percent equals 1.2 percent which is rounded to 1 percent. Former OAR 436-35-230(8); former OAR 436-35-007(14) and former OAR 436-35-007(11).

Claimant has 4/5 strength of the lateral plantar branch of the posterior tibial nerve. The maximum award for injury to that nerve is 6 percent. Thus, claimant is entitled to an award of 1 percent (20 percent multiplied by 6 percent equals 1.2 percent which rounds to 1 percent). Former OAR 436-35-230(8); former OAR 436-35-007(14) and former OAR 436-35-007(11).

Finally, claimant has 4/5 strength in the medial plantar branch of the posterior tibial nerve. The maximum award for injury to that nerve is 6 percent. Thus, claimant is entitled to an award of 1 percent (20 percent multiplied by 6 percent equals 1.2 percent which rounds to 1 percent). Former OAR 436-35-230(8); former OAR 436-35-007(14) and former OAR 436-35-007(11).

Claimant's impairments in the foot are combined and converted into a value for the leg. Former OAR 436-35-240(4). The values for claimant's foot (8, 1, 1, and 1) are combined to total 11 percent which is converted to 10 percent of the leg. Former OAR 436-35-210. Claimant's losses in the left leg (15, 5, and 4), are combined to total 22 percent. 22 percent is combined with the 10 percent converted foot findings to total 30 percent. Claimant's scheduled permanent disability under the "standards" is 30 percent for the left leg.

Unscheduled Permanent Disability

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 values is added to the impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

At the time of determination, claimant was less than 40 years old. Therefore, the appropriate value for age is 0. OAR 436-35-290(2).

Claimant has acquired a high school diploma. Therefore, the appropriate value for formal education is 0. Former OAR 436-35-300(3)(a). Claimant's highest SVP based on the jobs he has performed during the ten years preceding determination is 7 for a value of 1. The appropriate value for education is 1. Former OAR 436-35-300(4)(e).

In determining the extent of permanent disability, the adaptability factor is based on a comparison of the worker's job at the time of injury with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1). Former OAR 436-35-270(3)(h) provides that "'[s]trength' means the physical demands of each job as described th the SCODDOT. Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's at-injury job." Former OAR 436-35-270(3)(h).

At the time of his injury, claimant was employed as a "painter," which the DOT describes as a medium strength job. DOT# 840.381-010. Claimant contends that the painter job was actually in the very heavy category. However, the applicable standards reference the DOT in determining the value for prior strength. Claimant does not point to a DOT job description which more accurately reflects his actual job duties and which is described by the DOT as very heavy.

While we consider the record as a whole, including the job duties and the physical demands of the at-injury job, in determining which DOT is most applicable, the fact remains that the most applicable DOT determines the strength category of the at-injury job. Kathryn D. Parsons, 45 Van Natta 954 (1993); William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993). Since claimant does not contend that another DOT job description more accurately describes his job duties, we use the DOT strength description in determining the adaptability factor.

Here, claimant's job as a painter is described by the DOT as a medium strength job. Dr. Slack indicated that claimant was capable of light work with restrictions. Therefore, claimant's residual functional capacity (RFC) is sedentary/light. See Former OAR 436-35-310(3). Claimant's adaptability factor under the standards is 4. Former OAR 436-35-310(3).

The criteria for rating unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In his report, Dr. Slack rates impairment to claimant's right and left hips. However, no physician has indicated that the hip impairment is "due to" the compensable injury. Dr. Slack opines that claimant's low back and left leg conditions are causally related to his compensable injury. (Ex. 12a-2). Likewise, Dr. Hacker indicates that the compensable injury is the major cause of the low back and leg conditions. (Ex. 12-2). However, neither physician indicates that the hip impairment was caused by the December 1990 injury. Accordingly, we do not consider the hip condition in rating claimant's unscheduled disability. See ORS 656.214(5).

Dr. Slack found that claimant had 20 degrees loss of flexion in the lumbosacral spine which equals 7 percent impairment; 5 degrees of extension which equals 6 percent impairment; 15 degrees right lateral flexion which equals 2 percent impairment; and 18 degrees left lateral flexion which equals 1 percent impairment. See former OAR 436-35-360(19) to (21). Those values are added to equal 16 percent impairment due to lost ranges of motion in the lumbosacral spine. In addition, claimant is unable to repetitively use his lumbosacral spine. Accordingly, he is entitled to 5 percent for a chronic condition. Former OAR 436-35-320(5). 16 percent combined with 5 percent yields 20 percent impairment.

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 (1) for claimant's education is 1. The product of that value and the value (4) for claimant's adaptability is 4. The sum of that product and the value (20) for claimant's impairment is 24. That value represents claimant's unscheduled permanent disability.

Penalties and Attorney Fees

Claimant seeks a penalty pursuant to ORS 656.268(4)(g). ORS 656.268(4)(g) provides for a penalty 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 disabled . . ." (Emphasis supplied). We have recently held that ORS 656.268(4)(g) does not provide for a similar penalty if the increase is awarded by a Referee or the Board. Cynthia L. Luciani, supra.[1] Accordingly, claimant is not entitled to a penalty under ORS 656.268(4)(g).

Claimant also contends he is entitled to an attorney fee pursuant to ORS 656.382(1) on the grounds that the insurer failed to make any scheduled award and because, claimant argues, the increased award should be in excess of 25 percent of the Notice of Closure and claimant is more than 20 percent disabled. We do not agree that the insurer unreasonably resisted the payment of compensation.

First, we have found that claimant is not entitled to a penalty pursuant to ORS 656.268(4)(g); second, claimant's increased permanent disability award is based on Dr. Slack's January 1992 report which was not even in existence and could not have been considered at the time of the insurer's August 1991 Notice of Closure. Under these circumstances, we conclude that the insurer did not unreasonably resist the payment of compensation. Accordingly, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1).

ORDER

The Referee's order dated July 2, 1992 is modified in part and affirmed in part. In addition to the Referee's award of 4 percent (6 degrees) scheduled disability for the left leg, claimant is awarded 26 percent (39 degrees), giving him a total scheduled award to date of 30 percent (45 degrees). In addition to the Referee's award of 10 percent (32 degrees) unscheduled disability for a low back condition, claimant is awarded 14 percent (44.8 degrees), giving him a total unscheduled award to date of 24 percent (76.8) degrees). The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total "out of compensation" attorney fee granted by the Referee's order and this order shall not exceed $3,800. The remainder of the Referee's order is affirmed.

[1] Recently, in Vena K. Mast, 46 Van Natta 34 (1994), we adhered to our reasoning in Cynthia L. Luciani, supra, that the Department must award the requisite increase in permanent disability for a penalty to be assessed under ORS 656.268(4)(g). However, we held that a Referee or the Board may reverse such a penalty if a Referee or the Board reduces the amount of permanent disability below the 20 percent disabled and 25 percent increase requirement.

In the Matter of the Compensation of
STEVEN L. CLINE, Claimant
WCB Case No. 93-00701
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Referee Black's order that assessed a penalty under ORS 656.268(4)(g). Claimant cross-requests review of that portion of the order that declined to award an attorney fee under ORS 656.382(1) based on the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are penalties and attorney fees.

We affirm and adopt those portions of the Referee's order entitled "Penalty Pursuant to ORS 656.268(4)(g)" and "Assessed Attorney Fee" and supplement the latter as follows.

Claimant requests a separate attorney fee be assessed pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. Claimant contends that the insurer's failure to award scheduled permanent disability for the loss of use of function of claimant's right thumb, rather than the mere loss of range of motion for one affected joint, constitutes unreasonable resistance to the payment of compensation. We disagree.

The imposition of a penalty under ORS 656.268(4)(g) by itself does not constitute grounds for awarding an assessed attorney fee under ORS 656.382(1). See Jesus R. Corona, 45 Van Natta 886 (1993). Under the statute, a fee is awarded if claimant establishes that the insurer unreasonably failed to pay compensation due or otherwise unreasonably resisted payment of compensation. Furthermore, the size of the mistake does not constitute unreasonable resistance. Claimant must show some activity by the employer that lead to the mistake and was unreasonable. See Clair A. Hand, 45 Van Natta 1543, footnote 1, (1993). Here, the Notice of Closure's permanent disability award was reasonably based on the attending physician's concurrence with a report by a medical examiner. Under these circumstances, we do not find SAIF's conduct to have been unreasonable within the meaning of ORS 656.382(1). See Clair A. Hand, supra; Beverly A. Kirk, 45 Van Natta 1078 (1993).

ORDER

The Referee's order dated May 13, 1993 is affirmed.

In the Matter of the Compensation of
LORETTA E. DILL, Claimant
WCB Case No. 92-12819
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Davis, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Baker's order that affirmed an Order on Reconsideration which declined to award claimant additional permanent disability for a left shoulder injury beyond the 10 percent (32 degrees) unscheduled award she had previously received. On review, the issue is extent of permanent disability (scheduled and unscheduled).

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

We acknowledge that claimant has twice undergone surgery for her compensable left shoulder condition since the October 9, 1987 Determination Order, the last arrangement of compensation. (See Exs. 2, 4). At the time of the first surgery and continuing through the second surgery, the claim was open. Claimant received additional temporary disability compensation because her condition worsened temporarily. However, to receive additional permanent disability compensation, claimant must establish that her condition has worsened permanently. See Stepp v. SAIF, 304 Or 375 (1987); OAR 436-35-005(5).

Based on the medical evidence, we agree with the Referee that claimant's left shoulder condition has not permanently worsened (resulting in diminished earning capacity) since the last arrangement of compensation. On the contrary, claimant's left shoulder condition has improved.[1] Under these circumstances, claimant is not entitled to redetermination of her permanent disability award. (Id).

ORDER

The Referee's order dated May 4, 1993 is affirmed.

[1] As of the last arrangement of compensation, claimant had the residual functional capacity to perform restricted light or sedentary/light work. (Ex. 13). Following claimant's second left shoulder surgery, no medical expert concluded that claimant's compensable condition had permanently worsened. In fact, Dr. Benz, treating surgeon, opined that claimant "was certainly better than she was preoperatively in either case." (Ex. 6). As of the Order on Reconsideration, claimant was capable of performing restricted medium or medium/light work. (Exs. 7-3, 12-4, 13).

In the Matter of the Compensation of
SHERRY Y. DROBNEY, Claimant
WCB Case No. 93-00292
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Spangler's order that affirmed a Director's order finding that surgery rendered to claimant's right leg was not appropriate. On review, the issue is whether substantial evidence supports the Director's order. See ORS 656.327(2). We reverse.

Preliminary Issue

At hearing, claimant offered a September 22, 1992 stipulation in support of her argument that the self-insured employer was precluded from denying the compensability of the surgery. The Referee explained that he did not receive the agreement as substantive evidence since it was not part of the record developed before the Director but that he would consider the document "as support" for claimant's preclusion argument. (Tr. 8).

On review, although the employer does not assert that the Board should not consider the stipulation, it points out that the document was not admitted for substantive purposes.

Subsequent to the Referee's order, we disavowed our holding in Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993), which held that review under ORS 656.327(2) of the Director's order by the Referee was limited to the record developed before the Director. Julie Sturtevant, 45 Van Natta 2344 (1993). Based on the text and context of ORS 656.327(2), the Board concluded that the legislature intended referees to independently find facts based upon an evidentiary record developed at hearing. Id. at 2347.

Based on Sturtevant, the Referee in this case was not limited to the record developed before the Director and could admit the stipulation into evidence. Therefore, since the stipulation is already in the record, we consider it for substantive purposes.

FINDINGS OF FACT

In May 1987, claimant compensably injured her right ankle. Dr. Puziss, claimant's treating orthopedic surgeon, performed seven surgeries on claimant's right ankle and foot between January 1988 and March 1990. In November 1990, a Determination Order awarded claimant 19 percent permanent disability.

In May and June 1991, claimant filed a request for hearing challenging the Determination Order and alleging that the employer had de facto denied a request for another surgery. On September 22, 1992, claimant and the employer entered into a stipulation stating that claimant had been seen by Dr. Burchiel on August 15, 1991 and that she would "follow through with the examination and studies recommended by Dr. Burchiel." The agreement further provided that, "[a]t the conclusion of the evaluation recommended by Dr. Burchiel, Claimant will have the option to pursue further surgery with Dr. Burchiel or with Dr. Puziss, as she chooses, to address her immediate request for surgery." Referee Thye approved the settlement and dismissed claimant's request for hearing with prejudice.

On September 24, 1992, Dr. Puziss performed an eighth surgery on the right ankle. On October 13, 1992, the employer requested review by the Director of the surgery, alleging that it was "excessive, inappropriate, and probably would be ineffectual." The Director issued an order finding that "the surgery performed on September 24, 1992 was not appropriate for [claimant's] condition" and that the employer was not required to pay for the surgery.

Claimant requested a hearing challenging the Director's order. The Referee found that substantial evidence supported the Director's findings and affirmed the order.

CONCLUSIONS OF LAW AND OPINION

The Director's order may be modified only if it is not supported by substantial evidence in the record. ORS 656.327(2). Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988).

As stated above, the stipulation provided that claimant agreed to "follow through with [Dr. Burchiel's] examination and recommendations" and that, at the conclusion of Dr. Burchiel's evaluation, claimant would have the option to "pursue" surgery with Dr. Burchiel or Dr. Puziss "to address her immediate request for surgery." The record shows that, prior to entering into the agreement, claimant underwent examinations by Dr. Ochoa and Dr. Olson, as well as a diagnostic placebo and local anesthetic block of the superficial peroneal nerve, all of which was recommended by Dr. Burchiel. (Exs. 141-5, 142, 143, 146). On September 22, 1992, Dr. Burchiel provided his final opinion regarding the proposed surgery. (Ex. 151).

Because claimant complied with Dr. Burchiel's recommendations, pursuant to the terms of the stipulation, claimant was entitled to "pursue" surgery with Dr. Burchiel or Dr. Puziss at the conclusion of Dr. Burchiel's evaluation. We find that the only reasonable construction of the agreement's provision that claimant could pursue surgery "to address her immediate request for surgery" is that the employer agreed to pay for claimant's requested surgery if claimant chose to pursue such medical treatment at the conclusion of Dr. Burchiel's evaluation. Since claimant satisfied the terms of the agreement by undergoing the recommended examinations and chose to have the surgery, we conclude that, according to the terms of the stipulation, the employer was obligated to pay for the surgery.

The employer argues that the agreement should be narrowly construed as providing only that the employer agreed not to contest the causal relationship between the surgery and the accepted condition. The employer bases this assertion on the contention that, because the Hearings Division at the time that the parties entered into the stipulation could only have resolved the issue of causation, and not the reasonableness and necessity of treatment, the stipulation necessarily only addressed causation.

We do not entirely understand the employer's argument. At the time the parties entered into the stipulation, the Board had held that the Director had original jurisdiction of disputes concerning whether medical treatment was inappropriate or ineffectual. Stanley Meyers, 43 Van Natta 2643 (1991).[1] Apparently, the employer asserts that the agreement should be construed as addressing only those matters over which the Hearings Division has original jurisdiction and, based on Meyers, the stipulation therefore was limited to causation.

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[1] The Court of Appeals subsequently reversed our order in Stanley Meyers, supra, holding that the Hearings Division has jurisdiction to address whether medical treatment is excessive, in appropriate, ineffectual or in violation of administrative rules unless a party "wishes" review by the Director under ORS 656.327(1). Meyers v. Darigold, Inc., 123 Or App 217 (1993).

In those cases where the parties have sought to enforce a stipulation, we have considered jurisdiction only because it was necessary to determine the reasonableness and necessity of the medical treatment in order to enforce the agreement. See e.g. Kathryn C. Kennedy, 44 Van Natta 2204 (1992). We have not construed the meaning of a stipulation in the context of the jurisdiction of the Hearings Division. Instead, we look to the terms of the agreement. See e.g. Lora L. Pittman, 46 Van Natta 5 (1994).

In this case, we have found that, based on the terms of the stipulation, the employer is obligated to pay for claimant's surgery. Consequently, we conclude that the Director's order finding that the surgery was inappropriate treatment is not supported by substantial evidence and we set it aside. See ORS 656.327(2).

ORDER

The Referee's order dated April 28, 1993 is set aside. The employer is responsible for claimant's September 24, 1992 surgery.

January 26, 1994 Cite as 46 Van Natta 135 (1994)

In the Matter of the Compensation of
ELDON A. HAWLEY, Claimant
WCB Case Nos. 92-06750
ORDER ON REVIEW
Susak, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband, Gunn, and Haynes.

The SAIF Corporation requests review of that portion of Referee Barber's order that set aside its denial of claimant's current condition. On review, the issue is compensability.

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

Based on the opinions of Drs. Gehling, Falcon and Boyd, the Referee concluded that claimant had established that his 1977 injury was a material contributing cause of his current condition. On review, SAIF contends that the appropriate standard of proof is the major contributing cause standard since, SAIF argues, the medical evidence establishes that claimant's current cervical condition should be analyzed as a secondary consequence of the 1977 compensable injury. We disagree with SAIF's contention.

A condition that arises belatedly is not necessarily a "consequential" condition. See Virgil A. Ray, 45 Van Natta 1085 (1993). The key inquiry is whether the condition or need for treatment is caused directly by the industrial accident or whether it is caused in turn by the compensable injury. ORS 656.005(7); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992); John G. Davison, Dcd, 45 Van Natta 389 (1993), aff'd Davison v. McDonnald & Weltel, 125 Or App 338 (1993).

Here, we find that claimant's current condition arose directly from the compensable injury. All of the physicians who address causation recognize that trauma can be the cause of claimant's current condition.

Dr. Boyd, claimant's attending physician, believed that claimant's condition resulted directly from the 1977 injury. In January 1992, when initially determining the potential causes of claimant's condition, he noted that the condition, if caused by the 1977 injury, could be "dependent on previous cervical spine trauma and injury with resultant degenerative joint changes and disc disease." In addition, a January 1992 MRI revealed a lesion at C5-6, which "could be a post-traumatic or compression type of myelopathy." (Ex. 12).

In February 1992, Dr. Falcon, a consulting neurologist, addressing the cause of claimant's condition, stated that the 1977 injury at least contributed a significant degree to claimant's current condition. He further stated: "It is not unusual that degenerative changes caused by an injury can progress with time." (Ex. 18).

Dr. Gehling, neurosurgeon, felt that there was a possibility that claimant's 1977 injury had some contribution to his present myelopathy. He also stated that there was a "remote chance" that claimant's 1977 trauma "predisposed his degenerative process to produce C-3, 4 and C-5, 6 process, although I am not convinced that he has had a myelopathy all this time."

Although not all of the physicians could state to a probability that the 1977 trauma was the cause of claimant's condition, we interpret their opinions to indicate that, if claimant's current condition is work-related, it results from a degenerative condition which was directly caused by trauma from the 1977 injury. Under such circumstances, claimant need only prove that the 1977 injury is a material contributing cause of his current condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

Even if the major contributing cause standard applied to this case, we would rely on the persuasive opinion of Dr. Boyd, claimant's treating physician, and find that claimant has satisfied that standard. Dr. Boyd opined that there was a reasonable medical probability that the 1977 injury was the "cause or the underlying cause" of claimant's current symptomatology. We interpret Dr. Boyd's opinion to mean that the major contributing cause of claimant's current condition is the 1977 injury. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) (no incantation of "magic words" or statutory language is required).

SAIF also contends that claimant's claim is barred by the 1980 Disputed Claim Settlement (DCS) of a prior aggravation claim. We disagree. The medical evidence supports a conclusion that claimant's condition has medically changed since the DCS. Specifically, all three physicians relate claimant's current cervical lesion to trauma induced degenerative changes which have occurred since the injury. Under such circumstances, we conclude that claimant's current condition is different than that settled by the 1980 DCS and that the present claim is not, therefore, barred by the prior DCS. See Southwest Forest Industries v. Archer, 109 Or App 349 (1991); Proctor v. SAIF, 68 Or App 333 (1984) (the preclusive effect of a prior DCS may be avoided only if claimant's current need for treatment is for a condition different from the condition at the time of the DCS).

Thus, we find, based on the medical evidence, that claimant's current condition is different from his condition at the time of the DCS. Furthermore, the 1980 DCS provided: "This stipulation in no way affects claimant's future right to file an aggravation claim." (Ex. 7-2). Accordingly, we agree with the Referee that claimant's claim is not barred by the 1980 DCS.

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 April 1, 1993 is affirmed. For services on review, claimant's attorney is awarded $750 payable by SAIF.

Board Member Haynes dissenting.

Based on the medical evidence, I would conclude that claimant's current cervical condition is a secondary consequence of the compensable injury. I would further conclude that the evidence does not support a finding that claimant's 1977 compensable injury is the major contributing cause of his current cervical condition.

The evidence indicates that claimant's current condition, if it is work-related, did not arise directly from the compensable injury, but developed over time. In this regard, Dr. Boyd opined in January 1992, that claimant's condition could be "dependent on previous cervical spine trauma and injury with resultant degenerative joint changes and disc disease." In addition, a January 1992 MRI revealed a lesion at C5-6, which "could be certainly post-traumatic or compression type of myelopathy related to the post-traumatic change, as well as some local moderately prominent disc protrusion." (Ex. 12).

In February 1992, Dr. Falcon, a consulting neurologist, addressing the cause of claimant's condition, stated that it was "not unusual that degenerative changes caused by an injury can progress with time." (Ex. 18). Dr. Gehling, neurosurgeon, opined that there was a "remote chance" that claimant's 1977 trauma "predisposed his degenerative process to produce C-3, 4, and C-5, 6 process, although I am not convinced that he had a myelopathy all this time."

Based on this medical evidence, I would conclude that claimant's current cervical condition (diagnosed as cervical stenosis and myelopathy), if it is work-related, is a secondary consequence of the injury since it developed as a result of degenerative changes which occurred after the injury. Under these circumstances, claimant's condition should be analyzed as a secondary consequence of the 1977 compensable injury.

I would also find that the evidence does not support a conclusion that the 1977 injury is the major contributing cause of claimant's current condition. Dr. Falcon, neurologist, could not state what the major cause of claimant's current condition was. Dr. Gehling, a consulting neurosurgeon, felt that the 1977 injury had a small contribution to claimant's current condition. Only Dr. Boyd opined that the 1977 injury was the "cause or underlying cause" of claimant's current symptomatology.

Dr. Boyd attributes claimant's condition to the 1977 injury. However, he does not quantify the amount of contribution made by that injury. Although "magic words" or statutory language is not required, I would find that Dr. Boyd's opinion does not establish that the 1977 injury is the major contributing cause of claimant's current condition.

Specifically, I would conclude that Dr. Boyd's opinion is weakened by his final opinion, which at one point states that there is a probability that the 1977 injury is the cause or underlying cause of claimant's symptoms, and at another point states that the etiology of claimant's condition "may have" been work-related. Given these circumstances, and the contrary opinions of Drs. Gehling and Falcon, Dr. Boyd's opinion does not support a conclusion that the 1977 injury is the major contributing cause of claimant's current condition.

Because I would find based on the record, that claimant's current condition is not compensable, I respectfully dissent.

In the Matter of the Compensation of
DAMON R. ROBINSON, Claimant
WCB Case No. 92-16308
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
James W. Moller (Saif), Defense Attorney

Reviewed by Board Members Westerband and Hall.

Claimant requests review of that portion of Referee Barber's order which upheld the SAIF Corporation's denial of his low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, we do not adopt the Referee's findings of ultimate fact. Instead, we make the following findings of ultimate fact.

Claimant sustained an injury at work on August 18, 1992, when he fell from a log.

The August 18, 1992 work injury was at least a material contributing cause of claimant's subsequent back complaints.

CONCLUSIONS OF LAW AND OPINION

The Referee found, based on claimant's credible testimony, as well as the testimony of other witnesses, that claimant sustained a work injury on August 18, 1992. After our review of the record, we agree that claimant's testimony is credible. We further find his testimony reliable regarding the work incident and his subsequent back complaints. After our review of the record, we conclude that the discrepancies in claimant's description of the incident and date of injury are not sufficiently material to undermine the reliability of claimant's testimony. Accordingly, we agree with and adopt the Referee's finding that claimant sustained a work injury on August 18, 1992.

The Referee found, however, that the medical evidence in the record was not sufficient to establish a causal relationship between the work injury and claimant's back complaints. Therefore, he upheld SAIF's denial. We disagree.

In order to establish a compensable injury, claimant must prove, by a preponderance of the evidence, that his work injury was at least a material contributing cause of his disability or need for medical treatment. In addition, claimant must establish his compensable condition by medical evidence supported by objective findings. ORS 656.005(7)(a). Medical evidence is required to prove causation when that issue presents a complex medical question. See Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993).

Here, claimant first sought medical treatment from Dr. Baynes, an emergency room physician, on August 29, 1992. (Ex. 4). Dr. Baynes recorded the history of claimant's injury at work. Upon examination, he found "localized tenderness midline low lumbar region L4 to S1," and concluded that claimant's low back pain "apparently has resulted from on-the-job injury." (Ex. 4-2). He suspected a possible nerve root entrapment or a herniated nucleus pulposus, recommended conservative treatment, and referred claimant to an orthopedist for follow-up care.

Based on Dr. Baynes' examination and report, we find that claimant has established his injury with medical evidence supported by objective findings. In addition, we find that the circumstances of this injury do not present a particularly complex medical question. Therefore, we find that Dr. Baynes' examination and report is sufficient, under the circumstances of this case, to prove causation. Based on Dr. Baynes' report, we conclude that the August 18, 1992 work injury was at least a material contributing cause of claimant's disability and need for medical treatment for his low back condition.

Moreover, we find no contrary medical evidence in the record. Although Dr. German, the orthopedist who provided follow-up treatment, diagnosed claimant's condition as "[b]ack pain, etiology undetermined," we find that his comment refers to the physiological etiology of claimant's symptoms (i.e., whether claimant's symptoms were due to strain, ligament injury, or herniated disc), rather than

We conclude that claimant's back condition 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 $3,000, 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 appellate briefs, claimant's counsel's 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 28, 1993 is reversed. The SAIF Corporation's October 26, 1992 denial is set aside, and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DIXIE L. SCHMIEDEL, Claimant
WCB Case Nos. 92-15354 & 91-16027
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The self-insured employer requests review of that portion of Referee Myzak's order that set aside its denial of claimant's occupational disease claim for her bilateral ulnar nerve condition. In its brief, the employer contends that there are not objective findings to support the existence of an ulnar nerve condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

The employer denied compensability of claimant's ulnar nerve condition on the grounds that the condition was unrelated to, and did not arise out of or in the course of, claimant's employment. (Ex. 22).

FINDINGS OF ULTIMATE FACT

Claimant's work activities for the employer were not the major contributing cause of her ulnar nerve condition.

CONCLUSIONS OF LAW AND OPINION

On review, the employer argues, for the first time, that claimant has failed to establish the existence of her ulnar nerve condition. Claimant argues that, because the employer's denial did not dispute the existence of claimant's ulnar nerve condition, the employer is barred from raising that issue now. We need not address this argument because, even if we assume claimant has established the existence of the ulnar nerve condition, we conclude that the condition is not compensable.

The Referee concluded that claimant's ulnar nerve condition was compensable because Dr. Layman, claimant's treating physician, found an objective basis for the condition, and because his opinion was the most persuasive. We disagree.

Dr. Layman first opined that claimant's rapid, repetitive wrist and hand motions at work were the major contributing cause of her ulnar nerve condition. (Ex. 16-3). Later, during an October 23, 1992 telephone conversation with claimant's counsel, Layman changed his opinion. He responded to counsel's question regarding how claimant's work was related to her ulnar nerve condition by saying, "Well if you are doing repetitive flexion and extension of the elbow then you are likely to increase the swelling around the nerve and pinch the ulnar nerve at the elbow." (Ex. 24-6). He agreed with claimant's counsel that work that "requires leaning [on] your elbow, or permits leaning the elbows on a firm substance and working with the hands extended" will also cause an ulnar nerve condition like claimant's. (Id.) Layman also agreed that claimant's work was the major contributing cause of her ulnar nerve condition. (Id.)

The employer argues that, because the evidentiary record does not support a finding that claimant's work involved repetitive use of her elbows, and because Layman did not even suggest a relationship between claimant's elbow use and her ulnar nerve condition until his October 23, 1992 conversation with claimant's counsel, claimant has failed to meet her burden of proof. We agree.

Claimant must prove that her employment conditions were the major contributing cause of her ulnar nerve condition. ORS 656.802(2). "Major contributing cause" mean an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 198, 310 (1983); Enid S. Crowe, 45 Van Natta 1718 (1993).

We tend to give greater weight to a claimant's treating physician's opinions, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to give weight to the opinions of Dr. Layman, claimant's treating physician.

Although Layman has repeated the major contributing cause standard of ORS 656.802(2), we reject his opinions because his opinions are inconsistent and lack meaningful reasoning to aid us in evaluating his conclusions. See Somers v. SAIF, 77 Or App 259 (1986). Most importantly, as explained below, the preponderance of the evidence does not support his conclusions.

Layman's first opinion asserted that claimant's wrist and hand-intensive work activities were the major contributing cause of her ulnar nerve condition. However, he later changed the basis of his opinion, and asserted that claimant's elbow-intensive activities were the major contributing cause of that condition. Because Layman gives no explanation for his change of opinion, we do not find his opinion persuasive.

Additionally, we find insufficient evidence to support Layman's final opinion. There are two detailed work histories among the medical reports in this record.[1] One is in Dr. Nathan's report, the other is in Dr. Fuller's report. (Exs. 10-3, 15-2). Both histories focus primarily on claimant's job duties that required repetitive hand and wrist movements.

Although the record contains significant medical evidence pertaining to claimant's hand and wrist activities, it contains few references to claimant's elbow activities. Dr. Nathan stated that claimant was required to manipulate dough "with a short-arc wrist and elbow motion," and that she stretched dough using a "short-arc wrist motion and a mid-arc elbow motion." (Ex. 10-3). He also reported that claimant was required to climb ladders, which involved "a static cylinder prehension to grasp the ladder, coupled with short-arc wrist and elbow motion to pull herself up the ladder." (Id.) Nathan did not specify how frequently claimant engaged in these activities. Dr. Fuller reported that, when he examined claimant, she was working in a position that required her to use an overhead wheel about every 15 minutes, which caused her to experience "pain in her wrist and thumb, and some pain in the lateral aspect of the elbow." (Ex. 15-2).

The only other evidence in the record regarding claimant's elbow use is Layman's responses to claimant's counsel's questions during a October 23, 1992 telephone conversation. At the hearing, claimant did not testify specifically regarding her elbow activities at work.

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[1] Dr. Layman did not record a detailed work history for claimant; instead, he purported to rely on Dr. Nathan's history. (Ex. 16-3).

We conclude that the evidence is insufficient to establish that claimant's on-the-job elbow activities were the major contributing cause of her ulnar nerve condition. The history that Nathan recorded reveals that, at most, claimant was required to engage in an indeterminate amount of short- or mid-arc elbow motions. Other than Fuller's report that, when he examined claimant, she was required to pull an overhead wheel every 15 minutes, there is no evidence about how frequently claimant was required to engage in elbow-intensive motions at work. We are not convinced that claimant has proved that she was engaged in repetitive work-related elbow activities sufficient to meet the major contributing cause standard of ORS 656.802(2).

Dr. Layman's cursory statements to claimant's counsel on October 23, 1992 do not change our conclusion. Dr. Layman has apparently assumed that claimant was engaged in repetitive flexion and extension of her elbow; however, he never discusses any facts that might support that assumption. (See Ex. 24-6). Furthermore, we also have found no support for the assertion that claimant's work required "leaning [her] elbows on a firm substance and working with [her] hands extended."[2]

Finally, we are not persuaded by Dr. Layman's concurrence with claimant's counsel's statement that claimant's work was the major contributing cause of her ulnar nerve condition. (Id.) Because reciting "magic words" is not sufficient to carry claimant's burden of proof when the evidence does not support such a conclusion, see Debra L. Godell, 45 Van Natta 34 (1993), in this case, we discount Dr. Layman's opinion with respect to the cause of claimant's ulnar nerve condition.

In sum, we conclude that claimant has not met her burden of establishing that her work activities were the major contributing cause of her ulnar nerve condition. ORS 656.802(2). Therefore, claimant's claim for that condition is not compensable, and we reverse that portion of the Referee's order.

The Referee set aside not only the employer's "bilateral ulnar nerve condition" denial, but also a "bilateral carpal tunnel syndrome" denial. For claimant's counsel's services at the hearing regarding these denials, the Referee awarded a $2,500 attorney fee under ORS 656.386(1). Inasmuch as we have reinstated the "bilateral ulnar condition" denial, it is necessary to modify the Referee's attorney fee award.

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee award for claimant's counsel's services at hearing concerning the "bilateral carpal tunnel syndrome" denial is $1,750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as reflected by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated. We further note that claimant is not entitled to an attorney fee award for services devoted to the bilateral ulnar condition denial issue.

ORDER

The Referee's order dated May 3, 1993, is reversed in part and modified in part. That portion of the Referee's order that set aside the self-insured employer's denial of claimant's ulnar nerve condition is reversed. The employer's July 20, 1992 denial of claimant's ulnar nerve condition is reinstated and upheld. The Referee's attorney fee award is modified. In lieu of the Referee's attorney fee award, claimant's counsel is awarded $1,750, to be paid by the employer.

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[2] There is some evidence that claimant's work required her to lean on her palms when she stretched dough. (Ex. 10-3).

In the Matter of the Compensation of
MARK YAKIS, Claimant
WCB Case Nos. 93-01280 & 92-16172
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

EBI Companies requests review of that portion of Referee Holtan's order which awarded a $1,200 assessed attorney fee for its allegedly unreasonable compensability denial of claimant's hearing loss claim. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

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

On October 22, 1992, claimant's attorney, on claimant's behalf, filed hearing loss claims against Mastercraft Furniture and Standard Bag Manufacturing Co. At the time the claims were made, Safeco provided workers' compensation coverage for Standard Bag. EBI had provided coverage for Standard Bag during claimant's employment from January 1989 to April 1990. SAIF insured Mastercraft during claimant's 1987 to 1989 employment.

On December 14, 1992, EBI issued a compensability/responsibility denial of the claim. EBI based its denial on a September 1992 medical opinion authored by Dr. Hodgson. In that report, Dr. Hodgson traced claimant's employment and recreational noise exposure. Finding no recreational factors that would contribute to claimant's hearing loss, Dr. Hodgson concluded that "excessive noise exposure without hearing protection during [claimant's] employment at the Mastercraft Furniture Co. from 1987 - 1989 is the major contributing factor in [claimant's] current level of hearing loss."

Also on December 14, 1992, in response to Safeco's request for designation of a paying agent (.307 order), the Compliance Section requested additional information. Safeco replied on December 18, 1992, identifying the other potentially responsible insurers (including EBI). On December 28, 1992, the Compliance Section sought the position of EBI (as well as the other insurers) concerning the claim and Safeco's "307" request.

On January 12, 1993, EBI advised the Compliance Section (as well as claimant and the other insurers) that it was no longer contesting compensability of the claim, but rather was challenging responsibility. EBI acknowledged that its compensability denial had been issued "because at the time we did not have any medical or any further claim information in order to determine if compensability was an issue." (Ex. 19).

On January 19, 1993, the Compliance Section announced that, on January 18, 1993, SAIF had provided notification that it was accepting the claim. Consequently, the Compliance Section stated that no further action regarding the "307 order" request would be taken.

CONCLUSIONS OF LAW AND OPINION

Reasoning that there was no evidence that claimant's hearing loss was not compensable as to some employer, the Referee found that EBI's compensability denial had been unreasonable. Since there were no amounts then due on which to assess a penalty under ORS 656.262(10), the Referee awarded an attorney fee pursuant to ORS 656.382(1) for EBI's unreasonable resistance to the payment of compensation.

In reaching this conclusion, the Referee relied on Steven R. Holmes, 45 Van Natta 330 (1993). In

We agree with the Referee's conclusion that EBI's compensability denial was unreasonable. At the time of its denial, EBI had received Dr. Hodgson's opinion which related claimant's hearing loss to work exposure. The fact that the report attributed the loss to another employer would not provide support for a compensability denial. See Steven R. Holmes, supra. Moreover, EBI subsequently acknowledged that its compensability denial had been issued "because at the time we did not have any medical or any further claim information in order to determine if compensability was an issue." (Ex. 19).

In light of such circumstances, we are not persuaded that EBI had a legitimate doubt regarding the compensability of claimant's hearing loss claim. See Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Steven R. Holmes, supra; Harold R. Borron, 44 Van Natta 1579 (1992). Consequently, we hold that the compensability denial was unreasonable.

Inasmuch as the compensability portion of its denial was rescinded prior to hearing, the critical period for determining whether an amount is "then due" on which to base a penalty is the time of the rescission. See Linda M. Akins, 44 Van Natta 108 (1992). Because the record fails to establish that there were any amounts then due at the time of EBI's "compensability" rescission, no penalty shall be assessed. See William W. Clunas, 45 Van Natta 2234 (1993). Therefore, we proceed to a determination as to whether EBI's conduct constitutes an unreasonable resistance to the payment of compensation warranting the award of a carrier-paid attorney fee under ORS 656.382(1).

Noting that SAIF had not responded to claimant's claim or the "307 order" request by the time EBI rescinded its compensability denial, EBI contends that its conduct did not preclude the issuance of the order. Moreover, since SAIF accepted the claim well within 90 days of the filing of the claim, EBI argues that it did not delay the payment of claimant's compensation.

The Holmes, Clunas, and Borron rationale for the assessment of a penalty under ORS 656.262(10) or the award of a carrier-paid attorney fee under ORS 656.382(1) is based on the proposition that the nonresponsible carrier's unreasonable compensability denial prevented the issuance of a "307" order. See also Michael L. Whitney, 45 Van Natta 446 (1993). Here, EBI was one of several insurers who were required to advise the Compliance Section of their respective positions before consideration of Safeco's "307 order" request. Furthermore, as a result of SAIF's subsequent acceptance of the claim, it is now apparent that no "307" order would have issued.

Thus, the record does not support a conclusion that EBI's unreasonable compensability denial ultimately prevented the issuance of a "307" order. Nevertheless, the pivotal question for resolution is whether EBI unreasonably resisted the payment of compensation. See ORS 656.382(1). We are persuaded that the answer to that question is an unqualified "yes."

Rather than issuing its unreasonable compensability denial on December 14, 1992, EBI could have issued a responsibility denial and joined in Safeco's request for the designation of a paying agent. Since EBI did not choose this route in responding to the claim, the Compliance Section was required to seek clarification of EBI's position on December 28, 1992. The fact that it was necessary for the Compliance Section to also seek other carriers' positions does not absolve EBI from responsibility for its unreasonable conduct. Likewise, SAIF's subsequent January 20, 1993 acceptance does not mean that EBI did not unreasonably resist the payment of compensation through its compensability denial.

In essence, EBI's defense is based on the premise that the payment of claimant's compensation from SAIF would have occurred at the same time regardless of EBI's conduct. That may well be true. However, the focus of our analysis is on whether EBI unreasonably resisted the payment of compensation. Whether that eventual payment of compensation springs from the issuance of a "307" order or the acceptance of the claim, we consider an unreasonable compensability denial to constitute a resistance to that payment of compensation.

Accordingly, we hold that claimant's attorney is entitled to a fee under ORS 656.382(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee's conclusion that a reasonable fee for claimant's attorney's services regarding EBI's unreasonable resistance to the payment of compensation is $1,200. 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.

Alternatively, assuming that claimant was not entitled to an attorney fee award under ORS 656.382(1), we would conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing through the rescission of EBI's compensability denial. Under such circumstances, claimant's attorney would be entitled to a carrier-paid fee under ORS 656.386(1). See Penny L. Hamrick, 46 Van Natta 14 (1994). Applying the aforementioned rule to this case, we would also find the $1,200 attorney fee granted by the Referee to be reasonable.

ORDER

The Referee's order dated March 19, 1993 is affirmed.

In the Matter of the Compensation of
THOMAS D. ADAMSON, Claimant
WCB Case Nos. 92-12686 & 90-05391
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) admitted a post-closure medical report into the record; (2) increased claimant's award of unscheduled permanent disability for a neck injury from 27 percent (86.4 degrees), as awarded by an Order on Reconsideration, to 39 percent (124.8 degrees); (3) awarded claimant 29 percent (55.68 degrees) scheduled permanent disability for loss of use or function of the right arm and 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of the left arm whereas an Order on Reconsideration had not awarded any scheduled permanent disability; (4) assessed a 25 percent penalty pursuant to ORS 656.268(4)(g); and (5) awarded an assessed attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are evidence, extent of scheduled and unscheduled permanent 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

Evidence

We adopt the Referee's conclusions and reasoning concerning the admissibility of Exhibit 38A with the following supplementation.

SAIF contends that Exhibit 38A (an impairment calculation conducted by a physical therapist, whose findings were concurred in by claimant's attending physician) is not admissible pursuant to ORS 656.268(5) because it is based on a post-closure examination. We disagree.

Subsequent to the Referee's order, the Court of Appeals has held that, although the evidence that may be submitted on reconsideration before the Department is limited by ORS 656.268(5), under ORS 656.283(7) the evidence that may be submitted at a hearing before a referee is not so limited. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

We applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report from the attending physician, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7); 656.283(7)) were applicable. Id. Here, there is no other

basis preventing the admission of Exhibit 38A. Therefore, pursuant to Smith and Luciani, the Referee in this case had the authority to consider that exhibit.[1]

In addition, we note that while the examination that Exhibit 38A is based on was performed by a physical therapist, Dr. Hill, claimant's attending physician, concurred with those findings. Therefore, the findings in Exhibit 38A are not precluded by ORS 656.245(3)(b)(B). See Timothy J. Smith, 44 Van Natta 2246 (1992).

Extent of Unscheduled Permanent Disability

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

Extent of Scheduled Permanent Disability

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

Penalties

Inasmuch as claimant's award of permanent disability was increased by more than 25 percent and since claimant was more than 20 percent disabled, the Referee assessed a a penalty pursuant to ORS 656.268(4)(g). We disagree.

Subsequent to the Referee's order, we issued our decision in Cynthia L. Luciani, supra. In addition to applying the court's decision in Smith, we also discussed ORS 656.268(4)(g). In Luciani, we held that a penalty pursuant to ORS 656.268(4)(g) is available only if the requisite increase is awarded by the Department in its reconsideration order. Relying on the unambiguous language of the statute, we concluded that ORS 656.268(4)(g) was not applicable to increases in permanent disability that were awarded by a Referee or the Board. Id.

Here, SAIF's Notice of Closure awarded claimant 23 percent unscheduled permanent disability and no scheduled permanent disability. On reconsideration, the Department increased claimant's award of unscheduled permanent disability to 27 percent, but did not award any scheduled permanent disability. While claimant is at least 20 percent disabled, the Department did not increase claimant's award of permanent disability by 25 percent. Accordingly, a penalty pursuant to ORS 656.268(4)(g) is not warranted.[2]

Attorney Fees

The Referee assessed a penalty-related attorney fee under ORS 656.382(1) because he found that SAIF's Notice of Closure was unreasonable pursuant to ORS 656.268(4)(g). Inasmuch as we have found that claimant is not entitled to a penalty pursuant to ORS 656.268(4)(g) it follows that SAIF's Notice of Closure was not unreasonable on that basis. In addition, since the increase awarded by the Referee was based on Exhibit 38A, which was not available to SAIF at the time it closed the claim, [illegible]

Attorney Fees/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent issues is $1,200, 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. In addition, claimant is not entitled to an attorney fee for his counsel's efforts on review regarding the penalty and attorney fee issues.

ORDER

The Referee's order dated January 8, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which awarded a 25 percent penalty on the increased permanent disability award is reversed. In addition, that portion of the Referee's order which awarded a $1,500 penalty-related attorney fee is reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
OSCAR HERNANDEZ, Claimant
WCB Case No. 93-00741
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Podnar's order that: (1) found that claimant's claim had not been prematurely closed; (2) declined to award claimant unscheduled permanent disability; and (3) found that claimant's medically stationary date was March 7, 1992. In its brief, the insurer contends that the Referee erred in awarding claimant temporary disability benefits through March 7, 1992. On review, the issues are premature closure, extent of unscheduled permanent disability, medically stationary date, and temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's conclusions regarding premature closure.

The Referee authorized the insurer to recover temporary disability benefit payments made to claimant after March 7, 1992.[1] On review, the insurer argues that, under ORS 656.262(4)(b), claimant is entitled to temporary disability benefits only for the periods authorized by his treating physician. Therefore, it argues, because claimant's treating physician took him off work on November 6, 1991 and that authorization apparently was not renewed, (see ex. 20-3), the Order on Reconsideration correctly suspended claimant's temporary disability benefits as of December 6, 1991. We disagree.

ORS 656.262(4)(b) provides that an insurer may suspend temporary disability benefits if the insurer has requested verification of the worker's inability to work, and the worker's attending physician does not do so. Sandoval v. Crystal Pine, 118 Or App 640 (1993). The statute has two requirements: (1) The insurer must have requested from the worker's attending physician verification of the worker's inability to work; and (2) the physician must be unable to verify the worker's inability to work. Ronald Cameron, 45 Van Natta 219 (1993). The statute applies if those 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).

There is no contention, nor any evidence, that the insurer requested verification of claimant's inability to work from claimant's attending physician, or that the physician was unable to provide such verification. Accordingly, ORS 656.262(4)(b) does not apply. Ronald Cameron, supra.

Claimant was declared medically stationary on March 7, 1992. Therefore, inasmuch as the insurer has raised no other challenge to claimant's temporary disability award, we agree with the Referee that claimant is entitled to temporary disability benefits through March 7, 1992. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Claimant is entitled to an assessed attorney fee for services on Board review regarding the insurer's attempt to reduce claimant's temporary disability benefits. 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 counsel's services on review concerning the temporary disability benefits issue is $350, 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 reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 28, 1993, is affirmed. For services on Board review, claimant's attorney is awarded $350, to be paid by the insurer.

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[1] The Referee also authorized the insurer to recover temporary disability payments it paid to claimant for the period of October 29, 1991 to November 6, 1991. Neither party challenges that portion of the Referee's order.

In the Matter of the Compensation of
DALE A. KARSTETTER, Claimant
WCB Case Nos. 92-16156, 92-10388 & 92-11824
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cummins, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Howell's order which declined to award an attorney fee pursuant to ORS 656.386(1) for claimant's attorney's services in obtaining pre-hearing

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on John L. Law, 44 Van Natta 1619 (1992), concluded that claimant may not be awarded an assessed attorney fee under ORS 656.386(1), notwithstanding the fact that claimant's attorney was instrumental in obtaining concessions of compensation from Liberty/DLB and SAIF/Burroughs.

Subsequent to the Referee's order, the Board, in Penny L. Hamrick, 46 Van Natta 14 (1994), held that the claimant was entitled to a carrier-paid attorney fee award under ORS 656.386(1) when a carrier rescinded the compensability portion of its denial prior to a hearing regarding the responsibility of a claim.

Reexamining Multnomah County School District v. Tigner, 113 Or App 405 (1992) (the holding on which Law was based), the Board determined that the Tigner holding did not compel the Law decision. Specifically, the Board noted that the only carrier in Tigner who had denied "compensability" had been dismissed as a party to the responsibility proceeding. Thus, the Board identified the Tigner court's precise holding to be that "claimant cannot bootstrap entitlement to insurer paid attorney fees on a nonparticipating insurer's denial of compensability." Inasmuch as all carriers were participating in the Hamrick responsibility hearing (as was the case in Law), the Board reasoned that the claimant's counsel was entitled to a carrier-paid attorney fee under ORS 656.386(1) for obtaining compensation for the claimant without a hearing. See SAIF v. Allen, 124 Or App 183 (1993).

Here, SAIF/DLB issued compensability/responsibility denials of claimant's low back condition prior to the originally scheduled October 28, 1992 hearing. (Ex. 22). Liberty/DLB initially issued a disclaimer of responsibility only and requested an order designating a paying agent pursuant to ORS 656.307. (Ex. 26). SAIF/Burroughs did not issue a denial prior to the first hearing.

On October 28, 1992, SAIF/DLB rescinded its compensability denial. Furthermore, SAIF/DLB agreed to pay claimant's former attorney a fee of $1,000. (Closing arguments at 9). The October 28, 1992 hearing was postponed and reset for March 10, 1993. Subsequent to the continued hearing, SAIF/Burroughs issued a compensability/responsibility denial, and Liberty/DLB issued a compensability denial. However, prior to the rescheduled hearing, SAIF/Burroughs and Liberty/DLB had rescinded their compensability denials. (Ex. 37). SAIF/DLB was ultimately found responsible for claimant's low back condition.

The Referee found, and we agree, that claimant's present attorney was retained after SAIF/DLB rescinded its compensability denial before the first hearing and was paid an attorney fee in conjunction with that rescission. Thus, claimant had not shown that, with respect to SAIF/DLB, his present attorney was instrumental in obtaining compensation without a hearing.

The Referee further found that claimant's attorney was instrumental in obtaining concessions of compensation from Liberty/DLB and SAIF/Burroughs. We agree, and conclude that claimant is entitled to a carrier-paid attorney fee from Liberty/DLB and SAIF/Burroughs for his counsel's efforts in obtaining compensation for claimant without a hearing. Penny L. Hamrick, supra.

Alternatively, even if we interpreted the rescission of the carriers' denials as occurring during the hearing process (after the first hearing and before the continued hearing), claimant would still be entitled to an attorney fee under ORS 656.386(1). See Safeway Stores, Inc. v. Hayes, 119 Or App 319, 322 (1993) (in interpreting ORS 656.386(1), the court held that if the legislature intended that an attorney fee be available if a hearing is not held, it most certainly intended that an attorney fee be available if a hearing is held and the claimant prevails by reason of a stipulation or withdrawal of the denial before the referee has had the opportunity to issue an order).

concerning each rescission of the compensability portions of the denials issued by Liberty/DLB and SAIF/Burroughs. Therefore, claimant's attorney is granted two separate $750 attorney fee awards, one award payable by Liberty/DLB and one payable by SAIF/Burroughs. In reaching this conclusion, we have considered the time devoted to the issues (as represented by the record), the complexity of the issues presented, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated April 6, 1993 is reversed in part and affirmed in part. For claimant's counsel's pre-hearing efforts in obtaining the withdrawal of Liberty's compensability denial and SAIF/Burroughs' compensability denial, claimant's attorney is granted two separate attorney fee awards of $750, one payable by Liberty/DLB and one payable by SAIF/Burroughs. The remainder of the order is affirmed.

In the Matter of the Compensation of
CINDY LANKFORD, Claimant
WCB Case No. 92-06391
ORDER ON REVIEW
David R. Nepom, Claimant Attorney
Allen, Stortz, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Bethlahmy's order that found she was not a subject worker. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is a licensed jockey. Race horses typically are exercised in the morning and raced at night. Some persons are licensed only to perform exercise rides. Jockeys are licensed to exercise horses as well as race them. Jockeys exercise the race horses for a number of reasons, including the opportunity to be observed by the owners and trainers for races.

In September 1991, claimant asked Claude Copeland if she could exercise his horse. Mr. Copeland accepted the offer, telling claimant to warm up the horse "real good." During the ride, claimant was severely injured.

The Director found that claimant was not a subject worker of Mr. Copeland at the time she was injured and, therefore, her claim could not be processed. Claimant requested a hearing. The Referee also found that claimant was not a subject worker. Claimant challenges this conclusion, asserting that she was not an independent contractor or casual worker.

A "subject employer" is one who employs one or more subject workers. ORS 656.005(25), 656.023. All workers are "subject workers" except those described in ORS 656.027. ORS 656.005(26). Neither "independent contractors" nor "casual" employees are "subject workers." See ORS 656.027(7), 656.027(3).

"Independent contractors" are defined in ORS 670.600. ORS 656.005(29). An individual who "performs labor or services for remuneration" is treated as an independent contractor if all of the factors contained in ORS 670.600 are met. Liberty Northwest Ins. Corp. v. Potts, 119 Or App 252 (1993). We first note that, although claimant did not actually receive any payment, Mr. Copeland intended to offer claimant $5, and claimant expected to be paid $5, for exercising Mr. Copeland's horse. Therefore, we find that claimant performed such services for remuneration.

Furthermore, we find that not all of the factors contained in ORS 670.600 are met. In particular, claimant did not furnish the tools or equipment necessary for exercising the horse. See ORS 670.600(3). The record shows that Mr. Copeland supplied a saddle, bridle, and girth and that claimant furnished only her whip and helmet. Consequently, we find that at least a portion of the equipment "necessary" to exercise the horse was furnished by Mr. Copeland rather than claimant. Furthermore, the evidence shows that only Mr. Copeland hired persons to exercise his horses and that claimant had no authority to hire or fire other persons to perform this service. See ORS 670.600(4).

Accordingly, having failed to meet all of the factors, we conclude that claimant should not be considered an independent contractor. See Liberty Northwest Ins. Corp. v. Potts, supra.

We agree, however, with the Referee's conclusion that claimant's employment was "casual" and adopt that portion of her order. See ORS 656.027(3)(b).

ORDER

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

January 27, 1994 Cite as 46 Van Natta 150 (1994)

In the Matter of the Compensation of
LORENZO OROZCO-SANTOYA, Claimant
WCB Case No. 92-14664
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Garaventa's order that affirmed an Order on Reconsideration awarding 5 percent (16 degrees) unscheduled permanent disability for a right shoulder condition. In its brief, the insurer asserts that the Referee abused her discretion in admitting Exhibits 38B and 38B. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

During reconsideration before the Director, claimant submitted Exhibit 38A (a report dated September 25, 1992 from claimant's treating orthopedic surgeon, Dr. Poulson, to claimant's attorney) and Exhibit 38B (a letter drafted by claimant's attorney with which Dr. Poulson concurred on November 3, 1992). On the basis that the medical reports were not timely submitted, the documents were not considered during reconsideration.

At hearing, claimant again offered the documents. The Referee admitted them into evidence over the insurer's objection, finding that neither the statutes nor administrative rules prevented their admission. On review, the insurer objects to this ruling.

Subsequent to the Referee's order, the Court of Appeals held that ORS 656.268(5) did not prevent a referee from considering evidence at hearing that could not have been submitted to the Director on reconsideration. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Based on Smith, we have held that medical reports, even though not considered on reconsideration pursuant to ORS 656.268(5), are admissible at hearing provided that no other statutory limitations on evidence are applicable. Cynthia L. Luciani, 45 Van Natta 1734 (1993).

We agree with the Referee that no statutory provisions prevent the admission of Exhibits 38A and 38B. First, the treating physician either authored or concurred with the documents. Thus, there is no contravention of ORS 656.245(3)(b)(B), which provides that only the attending physician may make findings regarding the worker's impairment for purposes of evaluating disability. See Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666 (1994).

Furthermore, although a medical arbiter initially rendered a report on October 19, 1992, he provided a clarification report dated November 4, 1992. Inasmuch as the November 4, 1992 report merely clarified the medical arbiter's initial findings, we find that the document constitutes "findings of a medical arbiter" rather than "subsequent medical evidence" under ORS 656.268(7). See Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993) (ORS 656.268(7) prohibits admission of evidence developed after the medical arbiter's report, not the actual medical arbiter's report).

Because Exhibits 38A and 38B were rendered before the medical arbiter's November 4, 1992 "findings" and clarification report, we also find that the exhibits are not "subsequent medical evidence" under ORS 656.268(7). Therefore, the statute does not prohibit the admission at hearing of the November 4, 1992 report or Exhibits 38A and 38B.

Finally, because the disputed exhibits were not generated after the issuance of the Order on Reconsideration, we find that ORS 656.283(7) does not limit their admissibility.

Therefore, even though Exhibits 38A and 38B were not considered on reconsideration, we conclude that they were properly admitted into evidence at hearing.

Extent of Unscheduled Permanent Disability

The Referee affirmed the Order on Reconsideration awarding 5 percent permanent disability. Specifically, the Referee found that, although claimant proved 5 percent impairment, that amount was not increased because the proper value for adaptability was zero. Claimant challenges this finding, arguing that claimant proved an adaptability factor of 3.

Adaptability 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 (RFC) at the time of determination. OAR 436-35-310(1) (WCD Admin. Order 6-1992). At the time of injury, claimant was harvesting hops. (Ex. 7). This work is consistent with Grain Farmworker I, DOT 401.683-010, which has a strength demand of medium. See OAR 436-35-270(3)(g).

With regard to claimant's RFC, there was evidence from claimant's treating physician that claimant was limited to medium work. (Exs. 26, 38A, 38B). Dr. Burr, medical arbiter, reported that claimant had "minimal residuals to overall function" and was capable of heavy labor, although, when using only the right arm, claimant was limited to light to medium work. (Ex. 39-4).

The Referee found that Dr. Burr's opinion was more persuasive because he examined claimant in October 1992, in comparison with Dr. Poulson, who last examined claimant in April 1992, and, therefore, had a more complete history of claimant's work activities subsequent to April 1992, including berry picking and cannery work. We disagree.

First, claimant's berry picking and cannery work do not show that he is capable of heavy work since such activities are classified as medium and light work. See DOT 403.687-018, 529.686-014. Furthermore, we find that Dr. Burr's opinion is not as well reasoned because, even though he rated claimant's overall capacity as heavy, he found that claimant's capabilities when using only his right arm was light to medium.

Thus, we defer to Dr. Poulson's opinion that claimant's RFC is medium. Comparing this "medium" RFC to the "medium" strength demand at the time of injury results in a value of 0 for adaptability. See OAR 436-35-310(2).

There is no dispute that claimant proved 5 percent impairment. Having found that the adaptability factor is 0, claimant is entitled only to 5 percent unscheduled permanent disability. See OAR 436-35-280(6). Therefore, we agree with the Referee that the Order on Reconsideration should be affirmed.

ORDER

The Referee's order dated March 22, 1993 is affirmed.

In the Matter of the Compensation of
OLGA G. SEMENIUK, Claimant
WCB Case No. 93-00755
ORDER ON REVIEW (REMANDING)
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Emerson's order that dismissed claimant's hearing request concerning an Order on Reconsideration because claimant failed to appear at the scheduled hearing. Asserting several reasons for her failure to attend the hearing, claimant seeks reconsideration of the dismissal of her hearing request. The insurer has moved for an order dismissing claimant's request for Board review of a Referee's order on the ground that notice of the request was not timely provided to the parties. We deny the insurer's motion and remand.

FINDINGS OF FACT

The Referee's order issued September 17, 1993. The Referee dismissed claimant's hearing request regarding an Order on Reconsideration because claimant failed to appear at the hearing. The Referee granted the insurer's request to recover an overpayment against claimant's future permanent disability awards.

On Monday October 18, 1993, the Board received claimant's request for review of the Referee's order. In the request, claimant's representative asserted several reasons why claimant or an Oregon attorney had been unable to attend the hearing. The request did not indicate that all parties to the proceedings 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. Consequently, on October 28, 1993, we issued an Order of Dismissal.

On November 8, 1993, claimant's representative provided a "Certificate of Service" indicating that claimant's request for review was mailed on October 15, 1993 to the insurer's attorney. On November 22, 1993, we abated our Order of Dismissal and sought the parties' further responses. By affidavit, the insurer's attorney replied that the attorney's office had not received a copy of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies 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). In the absence of prejudice to a party, timely service of a request for review on an employer's insurer or attorney, is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance Co. v. King, 63 Or App at 850-51; Nollen v. SAIF, 23 Or App 420, 432 (1975); James R. Goings, 45 Van Natta 2119 (1993).

In response to the Board's Order of Dismissal, claimant's out-of-state attorney has submitted a signed Certificate of Service, indicating that claimant's request for review of the Referee's September 17, 1993 order was mailed to the insurer's attorney on October 15, 1993. By affidavit, the insurer's counsel stated that the attorney's office did not receive the request for review.

Claimant's proof of service by mail is in compliance with the Board's rules. See OAR 438-05-046(2)(a), (b). Thus, this service by mail was complete upon mailing. The insurer's counsel's apparent lack of receipt of the copy of claimant's request for review does not establish that a copy of the request for Board review was not mailed as claimant's representative's Certificate of Service represents. Nellda J. Morris, 44 Van Natta 1820 (1992); Franklin Jefferson, 42 Van Natta 509 (1988).

Under such circumstances, we find that claimant has established that she mailed a copy of her request for Board review to the insurer's counsel within 30 days of the Referee's September 17, 1993 order. Finding no prejudice to the insurer through this service on its attorney, we hold that we retain jurisdiction over claimant's request for review. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Nollen v. SAIF, supra. Accordingly, we deny the insurer's motion to dismiss claimant's request for Board review.

We proceed to a review of the merits of claimant's appeal. After conducting our review, we conclude that remand is warranted.

A Referee shall dismiss a request for hearing if claimant and her attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or 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. Harold Harris, 44 Van Natta 468 (1992); Vincent G. Iacoban, 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, through her representative, claimant has provided explanations for her failure to appear at the hearing. Primarily, these excuses describe claimant's relocation in Pennsylvania, as well as her inability to obtain an attorney in Oregon and an interpreter who speaks her Ukrainian language.

Considering these circumstances, we interpret claimant's submissions as a motion for postponement of the scheduled hearing. Inasmuch as the Referee did not have an opportunity to rule on the motion, this matter must be remanded to the Referee for consideration of the motion. Harold Harris, supra.

We emphasize that our decision should not be interpreted as a ruling that a postponement should be granted.[1] 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. See Harold Harris, supra; Ray Eaglin, 43 Van Natta 1175 (1991).

Accordingly, the Referee's order dated September 17, 1993 is vacated. This matter is remanded to Referee Emerson 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.

ORDER

The Referee's order dated September 17, 1993 is vacated. This matter is remanded to Referee Emerson for further proceedings consistent with this order.

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[1] We further note that, since the costs of traveling to Oregon to attend a hearing are generally borne by the parties, such circumstances have not been considered extraordinary for purposes of obtaining a postponement of a scheduled hearing. Richard A. Hogenson, 42 Van Natta 579 (1990).

In the Matter of the Compensation of
BLANCINA ARIETA, Claimant
WCB Case No. 93-00902
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of those portions of Referee Schultz's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award interim compensation from August 21, 1992 through November 16, 1992, as well as penalties and attorney fees. On review, the issues are compensability, interim compensation and penalties and attorney fees.

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

Claimant asserts that she is entitled to additional interim compensation from August 21, 1992 through November 16, 1992 because the noncomplying employer had notice or knowledge of the claim on or about August 6, 1992. We disagree.

SAIF was obligated to begin payment of interim compensation within 14 days of referral of the claim by the Director. ORS 656.054(1). Thus claimant is not entitled to interim compensation commencing with the noncomplying employer's first notice of the claim. Instead, since the claim has not been found compensable, claimant's entitlement to interim compensation runs from 14 days after the Director referred the claim to SAIF. Steven J. Spaur, 44 Van Natta 2387 (1992), aff'd per curiam Spaur v. Ashenberner Lumber, 121 Or App 684 (1993). There is no evidence in the record that the Director ever referred the claim to SAIF, thereby triggering SAIF's duty to pay interim compensation. See Joseph E. Dabacon, 43 Van Natta 1962, 1963 (1991). Accordingly, claimant is not entitled to additional interim compensation.

ORDER

The Referee's order dated May 5, 1993 is affirmed.

In the Matter of the Compensation of
MARVIN GROVE, Claimant
WCB Case No. 92-10900
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes, and Hall.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the denial by the Department of General Services, Inmate Injury Fund, of his left hand injury claim on the ground that the claim was not timely filed with the Department. On review, the issue is timeliness of Inmate Injury Fund claim.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated May 28, 1993 is affirmed.

Board Member Hall dissenting.

ORS 655.520(3) requires that an Inmate Injury Fund claim be filed with the Department of General Services ("General Services") within 90 days after the injury. However, General Services has discretion to waive the filing requirement "on the ground that, for good and sufficient reason, the claim could not be filed on time." Id. Further, ORS 655.520(1) provides that Inmate Injury Fund claims shall be filed "in the manner provided for workers' claims in ORS chapter 656, to the extent not inconsistent with ORS 655.505 to 655.550."

Under ORS chapter 656, an employer receiving a worker's claim is required to assist in the processing of the claim. ORS 656.262(1). Among other assistance, the employer is required to forward the worker's claim promptly to its insurer for processing.

ORS chapter 655 is silent about how a claim is actually filed with General Services; it merely requires that the filing be done in a timely manner. Because inmates are in the physical custody of the Department of Corrections ("Corrections"), as a practical matter, claims by injured inmates are filed with Corrections, which then forwards the claims to General Services for processing. Hence, for claim processing purposes, Corrections and General Services stand in the shoes of the "employer" and the "insurer," respectively. For this reason, it is not inconsistent with ORS chapter 655 to require Corrections to forward claims promptly for processing, as employers are required to do under ORS chapter 656.

Here, it is undisputed that claimant submitted a completed claim form to his work supervisor within a few days after his injury occurred on June 13, 1991. The work supervisor, who was employed by Corrections, gave a copy of the completed form to claimant but does not recall what happened to the remaining two copies. Ordinarily, copies are submitted to the safety manager who then forwards a copy to General Services. In this case, however, the safety manager did not receive a copy of claimant's claim form, and a copy was not received by General Services until June 1992, a year after claimant's injury.

These facts are distinguishable from those in Dept. of Justice v. Bryant, 101 Or App 226 (1990), where the injured inmate did not timely file a claim with either Corrections or the Department of Justice (the agency then responsible for administering the Inmate Injury Fund). Rather, the inmate in Bryant informed his supervisor of the injury but was told not to file an accident report or a claim for benefits. The facts of this case are also distinguishable from those in William A. Stevenson, 44 Van Natta 96 (1992), where the injured inmate submitted infirmary notes and reports to Corrections, but did not timely file a claim with either Corrections or the Department of Justice. Because the facts of Bryant and Stevenson are distinguishable, I would not expand their holdings to apply here. Inasmuch as claimant in this case timely filed his claim with Corrections, and, through no fault of his own, the claim was not forwarded to General Services, I would conclude that the claim was timely filed in accordance with ORS 655.520(3).

Additionally, even if I had found that the claim was not timely filed under ORS 655.520(3), I would conclude that General Services abused its discretion in declining to waive the filing requirement in this case. Our authority to review General Services' action for abuse of discretion is grounded in ORS 655.525, which provides that "[a]n inmate . . . may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304."

Here, claimant did all that he could to file his claim in a timely manner. It was only because of error by Corrections that the claim was not timely filed. Under these circumstances, I would find that, "for good and sufficient reason, the claim could not be filed on time." Further, inasmuch as there is no dispute that claimant would be entitled to benefits if the claim was not barred on the timeliness grounds, I would conclude that the claim is compensable. For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
KATHERINE T. HECKER, Claimant
WCB Case No. 91-18100
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Westerband.

The self-insured employer requests review of that portion of Referee Black's order which set aside its current condition denial of claimant's bilateral hand/wrist symptoms. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In the present proceeding, the employer issued a denial of compensability of and responsibility for claimant's current condition on the ground that the symptoms related to her compensable March 1987 claim had resolved and that claimant's current symptoms and need for treatment were related to her current employment.[1] (Ex. 21).

The Referee found, relying on the opinion of Dr. Carter, that claimant's compensable occupational disease was a material contributing cause of claimant's current condition.

On review, the employer argues that its scope of acceptance was limited to carpal tunnel syndrome (CTS), based on the Board's 1990 order finding that claimant's CTS was a compensable occupational disease. The employer then argues that since it only accepted CTS and since claimant does not currently have CTS, claimant's current complaints and need for treatment are unrelated to her compensable condition. Alternatively, the employer argues that claimant is barred by res judicata, if she is attempting to relitigate whether her compensable condition is other than CTS.

In our prior decision, we found that, at the time of claim filing, claimant's symptom complex (condition) consisted of stiffness in her fingers and numbness in her hands, and that after terminating her employment, her symptoms were weakness, awkwardness, and occasional throbbing pain in her hands. Katherine T. Hecker, 42 Van Natta 1218 (1990). We further found that claimant's work activities were the major contributing cause of her bilateral hand and wrist symptom complex (condition), that these symptoms were attributable to CTS, and therefore, concluded that her CTS was a compensable occupational disease. Id.

We previously ordered the employer to accept a condition which encompassed hand/wrist symptoms which claimant had established were caused by work activities for the employer. The essential finding, in that decision, was that work was the major contributing cause of the condition (symptom complex) then requiring treatment or resulting in disability. The label or diagnosis applied to that condition was not essential to the compensability analysis or to the Board's holding. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). The instant case factually presents the "flip-side" to Proctor v. SAIF, 68 Or App 333 (1984) (a party cannot relitigate compensability of the same condition just because the (label) diagnosis has changed). Claimant is not barred by the doctrine of res judicata from proving that her current condition (symptom complex) is still causally related to the condition (symptom complex) which the Board previously found compensable, though the prior diagnosis may no longer be the most appropriate label to apply to the symptom complex.

[1] The record does not indicate that claimant filed a claim with the subsequent employer.

Although the Referee applied a material contributing cause standard, we find, without deciding the applicable causal standard, that claimant has established compensability under either the material or major contributing cause standard. We adopt the Referee's analysis of the medical evidence. This is a case dependent upon medical observations of claimant's condition over a period of years. We find, as did the Referee, the opinion of Dr. Carter, claimant's treating physician, to be more persuasive. Dr. Carter has treated claimant since April 1987, and is familar with her symptoms. Therefore, he is in a better position to render an opinion on the relationship between claimant's compensable condition and her current symptoms. See Weiland v. SAIF, 64 Or App 810 (1986); Givens v. SAIF, 61 Or App 490 (1983). The medical evidence establishes that claimant's current hand/wrist condition is related to her compensable condition.

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 $1,000, 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 statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 9, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the employer.

January 28, 1994 Cite as 46 Van Natta 157 (1994)

In the Matter of the Compensation of
LOIS J. SCHOCH, Claimant
WCB Case No. 92-09982
ORDER ON RECONSIDERATION (REMANDING)
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On December 29, 1993, we withdrew our December 3, 1993 order which vacated Referee Holtan's order that affirmed a Director's order under ORS 656.327(2) that found that a proposed surgery was inappropriate medical treatment. Noting that additional testimonial and documentary evidence which the Referee had excluded from consideration at hearing was already present in the record, we requested the parties' respective positions regarding whether remand for further development of the record was necessary.

In response to our abatement order, claimant has submitted additional medical reports and claim processing documents, as well as subsequent referees' orders (one which recently set aside a low back surgery "de facto" denial). In reply, the insurer raises no objection to our considering this dispute based on the record as previously developed before the Referee. However, should we determine that remand is the appropriate course of action, the insurer also has no objection to a decision returning this case to the Referee for further development.

As discussed in our prior order, this medical service dispute pertains to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, 123 Or App 464 (1993), we have determined that the Hearings Division, rather than the Director, has jurisdiction to resolve such a dispute. See Peter Britz, 45 Van Natta 2187 (1993). We have likewise held that this dispute was litigated under an erroneous standard of review; i.e., the "substantial evidence" standard of ORS 656.327(2). See Patricia D. Simmons, 45 Van Natta 2305 (1993). Concluding that the record was incompletely and insufficiently developed, under such circumstances we found a compelling reason to remand for further development of the record.

In reaching our prior conclusion, we erroneously stated that the record was limited to that developed before the Director. As correctly noted by claimant, additional testimonial and documentary

After reconsideration, we continue to conclude that remand is appropriate. Notwithstanding claimant's attempts to submit additional testimonial and documentary evidence and our ability to now consider such evidence, the fact remains that the parties were still litigating their respective positions under the assumption that the "substantial evidence" standard of review under ORS 656.327(2) was applicable. Inasmuch as we have subsequently held that this dispute should not be considered under such a review standard, we continue to find this record as presently developed (including the excluded testimonial and documentary evidence) to be incomplete and insufficient.

Moreover, such circumstances (the litigation of this dispute under an improper standard of review and the parties' failure to mutually acknowledge that remanding for further development of the record is not necessary) establish a compelling reason to remand. By remanding, the parties will be provided with an opportunity to present additional evidence on this proposed surgery dispute in accordance with the appropriate review standard. See Ronald J. Lombard, 46 Van Natta 49 (1994); Patricia D. Simmons, supra.

Finally, we note that, pursuant to Referee Podnar's January 10, 1994 order, the insurer's "de facto" denial of claimant's low back surgery request has been set aside. In light of such circumstances, the parties are requested to address on remand to Referee Holtan the effect, if any, the Board's holding in Sherry A. Young, 45 Van Natta 2331 (1993), has on this case.

Accordingly, on reconsideration, as supplemented herein, we republish our December 3, 1993 order which vacated the Referee's order and remanded for further proceedings consistent with our order. Following such proceedings, Referee Holtan shall issue a final appealable order.

IT IS SO ORDERED.

January 28, 1994 Cite as 46 Van Natta 158 (1994)

In the Matter of the Compensation of
DONALD R. STROM, Claimant
WCB Case No. 92-01423
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael V. Johnson's order that increased claimant's scheduled permanent disability award from 14 percent (6.72 degrees) for loss of use or function of the left thumb, as awarded by an Order on Reconsideration, to 15 percent (22.5 degrees) for loss of use or function of the left hand.[1] On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for bilateral carpal tunnel syndrome. In March 1991, claimant's treating orthopedic surgeon, Dr. MacCloskey, performed a left carpal tunnel release. In September 1991, a Determination Order issued awarding claimant 29 percent scheduled permanent disability for loss of use or function of the left arm. The January 17, 1992 Order on Reconsideration reduced the award to 14 percent for loss of use or function of the left thumb. The Referee concluded that claimant was entitled to an award of 15 percent permanent disability for loss of use or function of the left arm.

[1] The insurer initially also requested Board review. However, prior to conducting our review, the insurer withdrew its

Claimant asserts that he is entitled to 52 percent scheduled permanent disability. In particular, claimant contends that he proved loss of range of motion of his left thumb, loss of sensation of three fingers on his left hand, and loss of grip strength.

With regard to lost range of motion, we agree with the Referee that claimant is entitled to values for loss of flexion at the interphalangeal (IP) and metacarpophalangeal (MP) joints of the thumb. On August 23, 1991, Dr. MacCloskey indicated that claimant retained 70 degrees of motion at the IP joint, which entitles claimant to 6 percent impairment, see former OAR 436-35-050(1) (WCD Admin. Order 2-1991), and 50 degrees of motion at the MP joint, which entitles claimant to a rating of 9 percent, see former OAR 436-35-050(3). (Ex. 85). Furthermore, contrary to claimant's argument, we find these ratings more persuasive than those provided by Dr. MacCloskey on July 16, 1991. To begin, the August 1991 findings are the most recent observations by the attending physician concerning claimant's permanent impairment. Moreover, these findings were rendered closer in time to the Order on Reconsideration. See ORS 656.283(7) (providing that evaluation of a worker's disability is as of the date of the issuance of the Order on Reconsideration).

However, we agree with claimant that he is entitled to a rating for loss of extension of the carpometacarpal joint of the left thumb since such impairment was indicated by Dr. MacCloskey in his July 16, 1991 report and not contradicted by subsequent reports. Consequently, claimant receives a rating of 4 percent. See former OAR 436-35-075(2). Claimant is not entitled to a value for loss of flexion of the carpometocarpal joint. See former OAR 436-35-075(1).

Converting these values to hand values produces ratings of 2 percent, 3 percent, and 2 percent respectively. See former OAR 436-35-070(4).

Claimant next contends that he proved loss of sensation in his index, middle and ring fingers. We agree that Dr. MacCloskey reported sensory loss in those areas. (Exs. 84, 85). Under the applicable rule, however, impairment is rated according to the degree of lost sensation. See former OAR 436-35-110(1). Dr. MacCloskey simply reported that claimant had "numbness" in three of his fingers without providing the grade of sensory loss.

However, an April 9, 1992 "post-reconsideration" report from an independent medical examination (IME) also addressed sensory loss, indicating that claimant exhibited normal two-point discrimination in all his fingers except both middle fingers, where he exhibited a two-point discrimination of 7 mm on both sides. (Ex. 102-4). Dr. MacCloskey subsequently concurred with the report. Thus, the issue becomes whether the IME findings or Dr. MacCloskey's concurrence may be considered in evaluating claimant's permanent impairment.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994) (Board violated ORS 656.245(3)(b)(B) by receiving and considering impairment findings of an independent medical examiner). Impairment findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. OAR 436-35-007(8); Alex J. Como, 44 Van Natta 221 (1992).

Here, no medical arbiter was appointed. Thus, the prohibition of ORS 656.268(7) is not applicable. Moreover, since Dr. MacCloskey concurred with the report from the April 9, 1992 independent medical examination, ORS 656.245(3)(b)(B) does not limit consideration of Exhibit 102 for purposes of evaluating claimant's permanent impairment. Id.

ORS 656.283(7) directs referees to evaluate a worker's permanent disability as of the time of the reconsideration order. We have interpreted this provision as designating a point in time at which a worker's permanent disability is evaluated. Gary C. Fischer, 46 Van Natta 60 (1994). Thus, while it does not provide a clear statutory limitation on medical evidence concerning a worker's permanent disability, it does affect the relevancy of evidence that does not address a worker's condition at the pivotal "rating date" (the date of the reconsideration order). Id.

Whether "post-reconsideration" medical evidence is probative is determined on a case-by-case basis. Fischer, supra. Factors supporting consideration of such evidence include the absence of any change in the worker's condition between the reconsideration order and the examination; the performance of "new" tests on the same condition; or the performance of the same tests if prior testing was not valid. Id. Again, the relevance of such evidence is dependent upon the facts and circumstances of a particular case.

Here, Exhibit 102 was generated after the reconsideration order and is based on an examination that occurred after the reconsideration order. In the report, the physicians indicated that claimant remained medically stationary. In addition, the independent medical examination not only addressed sensory loss found earlier by Dr. MacCloskey, but also quantified the grade of sensory loss. In light of Dr. MacCloskey's earlier findings of sensory loss and the fact that claimant remained stationary, we find that Exhibit 102 is relevant to the evaluation of claimant's permanent disability under ORS 656.283(7) in that it addresses claimant's compensable condition which was unchanged from the time of the reconsideration order. Fischer, supra. Therefore, we consider that exhibit in rating the extent of claimant's permanent disability.

The evidence from Dr. MacCloskey that claimant has numbness in his middle finger, in conjunction with the panel's report, entitles claimant to a rating for "less than normal but protective sensation" of his whole middle finger, for a value of 26 percent. Converting this value to one for the hand results in 4 percent impairment.

Finally, claimant contends that he is entitled to a rating for loss of grip strength. Such impairment is rated when the cause is a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit. See former OAR 436-35-110(2). Here, although Dr. MacCloskey reported that claimant demonstrated less grip strength in his left hand in comparison to his right, (Exs. 83, 85), there is no evidence of nerve injury or that such a condition caused a loss of grip strength. Thus, we agree with the Referee that claimant is not entitled to a rating for loss of grip strength.

Combining claimant's impairment values results in a rating of 11 percent. See former OAR 436-35-007(10). Inasmuch as the Referee granted 15 percent scheduled permanent disability for loss of use or function of the left hand and the insurer has withdrawn its objection to that award, we affirm the Referee's order.

ORDER

The Referee's order dated April 19, 1993 is affirmed.

In the Matter of the Compensation of
CURT O. TEETER, Deceased, Claimant
WCB Case No. 92-11163
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Westerband and Haynes.

The insurer requests review of Referee Galton's order which modified an Order on Reconsideration that awarded the decedent 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of his left forearm and found that the decedent was permanently and totally disabled effective June 18, 1991. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

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

In 1986, the decedent was arrested for driving while intoxicated. However, he was not incarcerated. He did not return to his job at H.B. Fuller after leaving to participate in an alcohol rehabilitation program. (Ex. 80-29, 30).

In January 1990, the decedent was drinking 1/2 case of beer per day. (Ex. 78, 79). In May 1991, he was drinking a half-pint of liquor per day. (Ex. 84-4).

ULTIMATE FINDING OF FACT

The decedent's alcohol abuse condition was not disabling in 1988 before claimant sustained his compensable left wrist fracture.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the decedent's noncompensable, preexisting alcohol abuse condition became disabling before his February 4, 1988 left wrist injury and, thus, the compensable injury plus the preexisting disabling condition rendered the decedent permanently totally disabled. The Referee reasoned that the decedent's alcohol abuse condition was disabling because he had been terminated from his employment in June 1986 due to having been incarcerated as a result of alcohol abuse. We reverse.

ORS 656.206 defines permanent total disability as "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." A disability is preexisting if it predates the injury. Searles v. Johnston Cement, 101 Or App 589, rev den 310 Or 393 (1990). Moreover, the condition must be disabling, not merely preexisting. See Elder v. Rosboro Lumber Co., 106 Or App 16 (1991).

In the early 1980's, the decedent experienced bilateral elbow and carpal tunnel problems while working for his long-time employer, H.B. Fuller. His claim was accepted and closed April 30, 1986, with a 10 percent scheduled permanent disability award for each arm. (Ex. 37). By stipulation in October 1986, the award was increased to 20 percent for each arm. (Ex. 39).

The decedent received vocational assistance and returned to his regular job in December 1985. (Ex. 17). In February and March 1986, the decedent's employer reported that he was fully productive and doing very well at his job. (Ex. 28-2, 33-2).

The decedent's wife testified that, although the decedent was drinking beer daily, on the many occasions that she observed him at work at H.B. Fuller, he was successfully performing his job. (Tr. 26-27).

In June 1986, the decedent was convicted of driving while intoxicated and voluntarily sought treatment at an alcohol treatment facility. (Ex. 80-30). Although he did not return to work at H.B. Fuller, the decedent testified (at a prior hearing) that he was not fired and that he did not quit his job. Id.

Between June 1986 and late 1987 the decedent lived off his retirement/severance money from H.B. Fuller. (Ex. 80-31). There is no evidence that the decedent was unable to work during that period of time but, rather, the decedent chose to live off the money received from the former employer.

When the decedent's money ran out, he began working as a carpenter for the new employer in January 1988. (Ex. 80-24). The decedent worked approximately a month at the new job and, in February 1988, his wrist was broken in a compensable motor vehicle accident. He did not return to work after that injury.

The decedent's beneficiary contends that claimant's alcohol condition was disabling prior to his 1988 wrist injury, and that the preexisting alcohol abuse condition plus the wrist injury rendered the decedent permanently totally disabled. We agree, and the insurer concedes, that the alcohol abuse condition appeared to cause some disability in 1986 when the decedent was arrested for driving while intoxicated and voluntarily sought treatment for the condition. However, the medical evidence does not support a finding that claimant was disabled from his preexisting alcohol abuse condition at the time of the 1988 compensable injury. Moreover, because claimant successfully obtained full-time employment in

The decedent's beneficiary cites medical reports of Dr. Keizer, decedent's treating physician, and Dr. Hunt in support of the fact that the decedent was unable to work and that vocational assistance was not feasible. (Exs. 84, 88, 90). Those reports however, refer to the decedent's condition in 1991, more than three years after the decedent's 1988 injury. They do not support a conclusion that his alcohol abuse was disabling prior to the 1988 injury.

The decedent's beneficiary relies on the opinion of Mr. Ross, vocational consultant. Although Ross had never met the decedent, he testified that alcohol was a vocational impairment for the decedent before 1988. (Tr. 38). Ross based his opinion mainly on the fact that the record showed that the decedent's alcohol-related condition had lead to termination of his employment at H.B. Fuller. (Tr. 43). Nevertheless, Ross later admitted that alcoholics are often able to successfully perform gainful employment. (Tr. 45). Ross further admitted that, had the decedent's wrist injury not occurred, he would have been unemployable at some point in time subsequent to February 1988, although he did not know at what time. (Tr. 50). For those reasons, and the fact that we have previously found that claimant apparently was disabled in 1986, but not in 1988 prior to his wrist injury, we are not persuaded by Mr. Ross' opinion.

After our de novo review of the evidence, we agree that the decedent did have an alcohol abuse condition that apparently was disabling in 1986. We are not persuaded, however, that the alcohol condition was disabling in 1988, prior to the wrist injury. The medical evidence indicates that the decedent's disability developed as a result of the alcohol condition after the 1988 wrist injury. See Elder v. Rosboro Lumber Co., supra, 106 Or App at 19. Accordingly, we reverse.

ORDER

The Referee's order dated November 25, 1992 is reversed. The August 21, 1992 Order on Reconsideration is reinstated and affirmed.

In the Matter of the Compensation of
BARBARA J. WIKOFF, Claimant
WCB Case No. 91-09053
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Brown's order that set aside its denial of claimant's current right shoulder condition and related surgery. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

Claimant suffers from longstanding rheumatoid arthritis which preexisted her work for the employer. Claimant began working in the employer's floral shop but was later transferred to the employer's deli and bakery, where she was required to perform more lifting, reaching and other shoulder activity. She gradually developed worsening pain in the right shoulder and sought treatment with Dr. Aaronson.

In November 1988 claimant filed a claim for upper dorsal strain and "acute flare up rheumatoid arthritis" in the right shoulder. (Ex. 3). The employer initially denied the claim but later withdrew its denial by Stipulation and Order dated June 20, 1989. The stipulation provided

"IT IS HEREBY STIPULATED AND AGREED * * * that the employer's denial will be withdrawn in its entirety and claimant's claim for upper dorsal strain and rheumatoid arthritis of the right shoulder and arm will be accepted and processed * * *.

"* * * *

"IT IS FURTHER STIPULATED AND AGREED that the issue of whether claimant's work exposure caused a temporary or permanent worsening of claimant's rheumatoid arthritis involving the right shoulder and arm will be resolved in the future and according to available medical evidence." (Ex. 12).

Claimant's claim was later closed by Determination Order on February 12, 1990 with an award of 18 percent unscheduled permanent disability. By Stipulation and Order dated April 13, 1990, claimant was awarded an additional 10 percent unscheduled permanent disability, for a total award of 28 percent unscheduled permanent disability "on claimant's upper dorsal strain and right shoulder condition only." (Ex. 23).

Claimant continued to have progressively worsening symptoms in the right shoulder. X-rays in April 1991 revealed progressive destruction of the right shoulder humeral head since x-rays were taken in January 1989. (Ex. 28-2). Right shoulder replacement surgery was recommended and ultimately performed on August 14, 1991. On July 3, 1991, the employer issued a denial of the right shoulder condition and surgery.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's current right shoulder condition is the same condition that was accepted by the employer in 1989, the Referee concluded that the res judicata doctrine of "issue preclusion" barred the employer from denying the current condition and surgery.

We do not agree that the current denial is barred by issue preclusion. There is medical evidence that claimant's right shoulder condition has pathologically deteriorated since January 1989. (See Ex. 28-2). That evidence, along with claimant's history of progressively worsening symptoms, persuades us that claimant's current condition is not the same condition that was accepted by the employer in June 1989. See Kepford v. Weyerhaeuser Co., 77 Or App 363, 366-67 (1986). Based on that change in claimant's condition, we conclude that the doctrine of issue preclusion does not bar the employer from litigating the compensability of claimant's current condition. Argonaut Ins. v. Rush, 98 Or App 730 (1989); North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988).

Nevertheless, on the merits we conclude that claimant's current condition is compensably related to the right shoulder condition that was accepted by the employer. By the June 1989 stipulation, the employer accepted the right shoulder rheumatoid arthritis. In addition, the parties expressly reserved for future resolution the issue of whether the right shoulder rheumatoid arthritis had been worsened temporarily or permanently by claimant's work exposure. We interpret that stipulation as reserving for future resolution the issue of extent of claimant's permanent disability due to the accepted rheumatoid arthritis condition.

The extent issue became ripe for litigation upon issuance of the Determination Order which awarded claimant 18 percent unscheduled permanent disability for the accepted shoulder condition. Instead of litigating the extent issue, however, the parties entered the April 1990 stipulation which increased the unscheduled permanent disability award to 28 percent based "on claimant's upper dorsal strain and right shoulder condition only."

In so doing, the parties agreed that claimant has sustained a permanent worsening of the accepted rheumatoid arthritis condition, thereby effectively resolving the extent issue reserved by the June 1989 stipulation. Both stipulations were approved by prior referees, and have the finality and effect of a judgment. See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993); International Paper Co. v. Pearson, 106 Or App 121 (1991). Hence, the stipulations preclude the employer from now contending that it accepted only a temporary exacerbation of the rheumatoid arthritis. We conclude that the employer accepted a permanent worsening of the right shoulder rheumatoid arthritis condition.

The dispositive issue, therefore, is whether the right shoulder surgery is compensably related to the accepted rheumatoid arthritis in the right shoulder. Medical services are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245; Beck v. James River Corp., 124 Or App 484, 487 (1993). All of the medical evidence in the record shows that claimant's need for right shoulder replacement surgery was required for right shoulder rheumatoid arthritis. Therefore, we find that claimant has sustained his burden of proving that the right shoulder surgery is materially related to the accepted rheumatoid arthritis.

Furthermore, insofar as ORS 656.005(7)(a)(A) or (B) may apply to require claimant to prove causation under the "major contributing cause" standard, we find that the totality of the medical evidence is sufficient to sustain claimant's burden of proving that the accepted right shoulder rheumatoid arthritis was the major contributing cause of her need for shoulder surgery. Accordingly, we affirm the Referee's order setting aside the employer's denial.

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 compensability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 15, 1992, as reconsidered May 4, 1992, is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
SCOTT W. BOETZ, Claimant
WCB Case No. CV-93005
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Diane Brissenden, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Martha J. Brown, special hearings officer, on December 2, 1993, in Salem, Oregon. Applicant, Scott W. Boetz, was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Diane Brissenden, Assistant Attorney General. The court reporter was Debi Meaghers. Exhibits 1 through 23 were received and admitted into evidence. The record was closed December 2, 1993. Mary Ellen Johnson, claims examiner for the Department, and Officer Mark Nunn of the Canby Police Department, were present as witnesses for the Department. Tina M. Boetz was present as a witness for applicant.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated August 17, 1993. By its order, the Department denied applicant's claim for compensation filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on its findings that: (1) no crime was committed which caused injury to applicant within the meaning of ORS 147.015(1) and; (2) applicant's wrongful act substantially contributed to his injuries within the meaning of ORS 147.015(5) and 147.125(3).

FINDINGS OF FACT

The following facts are not in dispute. Applicant was 20 years old at the time of the incident. Applicant was living at home with his mother, his wife, and his younger brother and sister.

On the evening of June 6, 1992, applicant's brother Tom, 15 years old, was walking home from a school function. Two teenagers, Justin Hyatt, 16 years old, and Jesse Zegar, also 16, drove by Tom and verbally harassed him. Hyatt and Zegar also squirted Tom with a squirt gun. The bumper of the teenagers' car brushed Tom, but did not injure him. Tom ran home and slammed the door shut. Applicant observed his brother crying and heard Tom tell his mother that he had been harassed by "some guys" in a car.

Applicant's sister Christie, 17, was also walking home at approximately the same time. Hyatt and Zegar verbally harassed Christie and squirted her with a squirt gun. Christie threw a "squeeze-it" bottle which hit the teenagers' car. Upon arriving home, she told her family that she had also been harassed.

Applicant's family then heard a car horn and saw car lights outside. Zegar came up to the front door to, "see what (Tom's) problem was." Applicant opened the door and a confrontation occurred between Zegar and applicant. Hyatt came to the aid of Zegar and joined in the confrontation. Punches were exchanged and one of Zegar's teeth was broken in the incident. Hyatt then stated that he was "going to get a gun," and the two teenagers left.

Applicant's family called 911, and Officer Nunn arrived and took statements. Applicant did not initially appear to be injured, but shortly after Officer Nunn arrived, applicant collapsed. An ambulance took applicant to the hospital, where he was diagnosed with muscle strain and minor abrasions.

Zegar and Hyatt were eventually apprehended by the Canby police at a 7-11 store. Both admitted that they had harassed applicant's brother and sister, and that they went to applicant's home and participated in the confrontation. Hyatt stated that he pushed applicant off the front porch and struck applicant several times, but applicant did not strike him. Both also admitted that, following the scuffle, they had stated that they were leaving to get a gun. No criminal charges were filed against either Zegar or Hyatt.

Applicant received chiropractic treatment for his neck and back injuries. Applicant was fired from his job when he missed a day of work due to his injuries.

In addition to the above undisputed findings, I make the following findings.

Zegar arrived at the door of applicant's home to see "what (Tom's) problem was." Applicant answered the door to see what Zegar wanted, and Zegar responded, "I want him" (referring to applicant's brother Tom who was inside the house). Applicant then blocked Zegar's way and informed him that Zegar would have to "get by me first." When Zegar moved toward the door, applicant shoved Zegar away. Zegar shoved applicant back, and a fight ensued. Hyatt came to Zegar's aid, and applicant was shoved off the front porch. The fight continued on the ground until Zegar and Hyatt left, stating that they were "going to get a gun."

Based upon his demeanor at hearing, I find that applicant is credible. Both applicant's and the Department's witnesses also testified in an honest and straightforward manner.

CONCLUSIONS OF LAW AND OPINION

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

The Department's order denying compensation benefits to applicant was premised, in part, upon applicant's failure to establish the commission of a "compensable crime." A "compensable crime" is defined by ORS 147.005(4):

> "'Compensable crime' means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state."

The Department's conclusion that applicant was not the victim of a compensable crime is apparently based on the fact that the original incident occurred between Zegar and Hyatt and applicant's brother and sister. I do not find this fact to be dispositive.

Although the incident began with the harassment of applicant's brother and sister, it did not end there. The record establishes that, even though Tom had gone home and stayed inside the house, Zegar and Hyatt drove up to applicant's home in order to confront Tom a second time. It was Zegar's entrance onto applicant's front porch that brought applicant outside his home.

Additionally, Officer Nunn, the police officer who responded to the disturbance, believed that Zegar and Hyatt had trespassed on applicant's property by entering the front porch at 11 p.m. that night. Officer Nunn further described the confrontation as a "double assault," or "mutual combat," as he had determined that both parties were involved in the incident.

Under such circumstances, the fact that it was applicant's brother and sister that were initially involved in this incident does not preclude applicant from establishing that he was the victim of a compensable crime. Zegar and Hyatt's conduct did not end with the harassment of applicant's siblings, but continued upon their arrival at applicant's home and eventually led to applicant's involvement.

Moreover, although the Department noted that Zegar and Hyatt were juveniles, I do not find that fact to be persuasive evidence that no compensable crime was committed. Although the statute provides that a compensable crime must be committed by a person of "full legal capacity," that term is not defined in the statute or rules. Here, the statement of Officer Nunn establishes that both Zegar and Hyatt could have been charged with the crimes of trespass and assault. Under the circumstances, I conclude that, although Zegar and Hyatt may have been minors at the time of the incident, they were also persons of full legal capacity within the meaning of the statute.

Finally, although no charges were brought against Zegar and Hyatt, I do not find that the statute provides for such a requirement in order for applicant to prove a compensable crime. This aspect of the case is similar to the factual situation in Gary G. Legler, 41 Van Natta 1508 (1989). In Legler, the applicant was involved in a scuffle with another worker. The applicant was diagnosed with cervical and thoracic strain as a result of the incident. Although the applicant reported the incident to the police, the district attorney elected not to file charges. In Legler, it was reasoned that there may be numerous reasons that charges are not brought against a suspect; however, the statute does not require commencement of prosecution as a prerequisite to recovery of benefits. ORS 147.305; Legler, supra.

Similarly, in the present case, the fact that no charges were brought against Zegar and Hyatt does not preclude applicant from proving a compensable crime. For the aforementioned reasons, I disagree with the Department's decision, insofar as it denied benefits based upon its conclusion that there was no compensable crime.

The Department also denied benefits on the ground that applicant's act of grabbing Zegar by the throat substantially provoked Zegar and Hyatt and substantially contributed to the altercation.

Pursuant to ORS 147.015(5), applicant is entitled to an award under the Act, if the death or injury to the victim was not substantially attributable to the wrongful act of the victim. The Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim, and shall reduce or deny the award of compensation. ORS 147.125(3).

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

Applicant credibly testified that he became involved in the incident when Zegar appeared at his front door, stating that he wanted his brother. Applicant denied grabbing Zegar by the throat, although he conceded that he blocked Zegar's way and then shoved him when Zegar moved toward the house. Applicant was then shoved back by Zegar, which was followed by the additional confrontation with Hyatt and the fall off the front porch.

Officer Nunn took a statement from Zegar, in which Zegar indicated that after he knocked on the door, applicant answered the door and grabbed him by the throat. There is no record of a police statement taken from applicant after the incident. On behalf of applicant, applicant's wife filed a statement with the Department which explained that applicant was injured while trying to block Zegar's entrance into the house that night. At hearing, both applicant and his wife testified that applicant pushed Zegar when Zegar attempted to come into the house.

Based upon the credible testimony of applicant and his wife, I rely upon applicant's description of the incident. I disagree with the Department's argument that applicant's statement that Zegar would, "have to get by me first," was intended to provoke Zegar into a confrontation. Rather, after considering the testimony of applicant and his wife, I find that the statement is more reasonably construed to have been a warning to Zegar that he should not attempt to enter the house or to pursue applicant's younger brother. Additionally, Zegar appeared to be seeking access to applicant's home or toward applicant's brother prior to applicant making such a statement to Zegar.

Furthermore, based upon the testimony of applicant and his wife, I disagree with the Department's finding that applicant appeared at the door and began choking Zegar. Rather, I find that applicant did shove Zegar when Zegar indicated that he was going to enter applicant's home to go after his younger brother.

I note that the Department chose to rely upon the description of the incident as provided by Zegar. At hearing, the Department's claims examiner testified that she relied upon Zegar's description of the incident because both Zegar and Hyatt had admitted that they had harassed applicant's siblings and because they admitted stating that they were going to get a gun.

Although Zegar and Hyatt may have provided similar stories and may have admitted to some of their aforementioned conduct, I do not choose to rely upon their statements as provided in the record. A phone note taken by the Department indicates that when the Department spoke to Detective Nunn it

Accordingly, I find that, although applicant was involved in a shoving match on his front porch, the incident was initiated by the earlier actions of Zegar and Hyatt who harassed applicant's brother and sister and who then appeared at applicant's home in order to continue the harassment. I further find that applicant's act of warning and then shoving Zegar was reasonable action taken in response to Zegar's comments that he wanted applicant's younger brother and his movement toward the inside of applicant's home. Furthermore, I find that it was Hyatt's conduct in joining in the scuffle which led to an escalation of events and applicant's being pushed off the front porch and sustaining injuries.

Based on the record, I do not find applicant's conduct to have constituted an unlawful act. Rather, I find that applicant's conduct was a reasonable attempt to defend his younger brother, his home, and eventually, to defend himself from Zegar and Hyatt.

For these reasons, I conclude that applicant's conduct did not contribute to or provoke his injuries within the meaning of ORS 147.015(5) and 147.125(3). Consequently, I conclude that applicant is entitled to full benefits as a victim of a crime.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated August 17, 1993, be reversed. I further recommend that applicant's claim for benefits be remanded to the Department with instructions to accept and process the claim in accordance with law.

In the Matter of the Compensation of
ANTONIA ALONSO-CAMACHO, Claimant
WCB Case No. C3-03170
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

On December 10, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

As originally submitted, the parties' agreement stated in part that the total amount of permanent disability awarded on the claim is 5 percent (9.6 degrees) scheduled and 60 percent (192 degrees) unscheduled. The agreement further provided that claimant would be paid $4,000 to release her rights to certain workers' compensation benefits, and that claimant's attorney would receive an attorney fee of $1,000.

On January 28, 1994, the parties submitted an addendum to the agreement. The amendment eliminated the above-noted language concerning scheduled permanent disability benefits, and provided that the payment to claimant had been increased from $4,000 to $26,093.71, in exchange for claimant's release of rights to temporary disability, permanent disability, vocational rehabilitation, and survivor's benefits. Claimant's attorney fee was increased from $1,000 to $1,732. The payment to claimant had been increased to include amounts previously awarded for permanent partial disability that had not yet been paid at the time the CDA was submitted to the Board. See Kevin E. Sahlfeld, 45 Van Natta 1779 (1993).

The Sahlfeld order further provided comments to assist the parties to eventually achieve their objective in a manner that was in compliance with Board authority. The CDA in this case is in compliance with the comments provided in Sahlfeld. See also William U. Rosenthal, 46 Van Natta 120 (1994)(Board approved a CDA which followed the Sahlfeld directive and included an unpaid balance of the claimant's permanent disability award in the total consideration, rather than attempting to provide for a lower amount of consideration and acceleration of the unpaid award).

Furthermore, we conclude that claimant's increased award resulting from the parties subsequent revision of the proposed CDA is distinguishable from a case in which the amount to claimant is decreased by the parties' revision, and claimant's statutory 30-day period is reimplemented. See e.g. Mary A. Smith, 45 Van Natta 1072 (1993). Accordingly, we find no reason to treat the parties' amended agreement as a new CDA, or to require resubmission or reacknowledgment of the agreement. Richard R. Millus, 45 Van Natta 810 (1993); William U. Rosenthal, supra.

The amended agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' amended claim disposition agreement is approved. An attorney fee of $1,732, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

January 31, 1994 Cite as 46 Van Natta 169 (1994)

In the Matter of the Compensation of
DAVID W. DURYEA, Claimant
WCB Case No. 92-08105
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Lipton's order that found claimant permanently and totally disabled, whereas an Order on Reconsideration had awarded 24 percent (76.8 degrees) unscheduled permanent disability; 8 percent (15.36 degrees) scheduled permanent disability for the right arm; and 4 percent (6 degrees) scheduled permanent disability for the right leg (knee). In addition, the insurer contends that the Referee erred in not allowing its witness to testify as a vocational expert. On review, the issues are evidence and permanent total disability.

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

The insurer contends that the Referee erred in not considering Mr. Scully's testimony as expert vocational testimony. Assuming arguendo that the insurer is correct, we would still find that claimant has established permanent total disability, even after considering Scully's testimony.

The Referee allowed Mr. Scully to give his vocational testimony in the form of an offer of proof. (Tr. 175-188). Scully testified that he thought claimant could perform some work, such as bowling alley attendant, arcade attendant, electronics assembler or security guard. However, Scully acknowledged that each of these positions may have duties that claimant could not perform and therefore Scully could not state with certainty that claimant could perform the duties of these occupations without further information. (Tr. 185-186). Finally, while Scully testified that claimant had the potential to obtain work as a product solderer, claimant was not presently qualified to do that job. In this regard, claimant's ability to perform work in the future is not relevant to the evaluation of his current disability. See Gettman v. SAIF, 289 Or 609 (1989).

Thus, even considering Mr. Scully's testimony, we would continue to find that claimant has

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 $1,500, 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 10, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the insurer.

January 31, 1994 Cite as 46 Van Natta 170 (1994)

In the Matter of the Compensation of
MARY W. FULTON, Claimant
WCB Case No. 93-01041
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Podnar's order that declined to award her an attorney fee under ORS 656.382(2) or ORS 656.386(1), when the self-insured employer withdrew its hearing request from an Order on Reconsideration that increased claimant's award of permanent partial disability. On review, claimant contends that she is entitled to an employer-paid attorney fee under both ORS 656.382(2) and ORS 656.386(1).

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

Claimant argues that, by dismissing the employer's hearing request, the Referee implicitly found that the compensation awarded to claimant should not have been disallowed or reduced. Therefore, she argues, she is entitled to an attorney fee award pursuant to ORS 656.382(2). We disagree. One of the requirements of ORS 656.382(2) is that there be a decision on the merits that a claimant's award of compensation should not be disallowed or reduced. Strazi v. SAIF, 109 Or App 105, 108 (1991). Because the Referee's dismissal was not a decision on the merits, claimant is not entitled to an award of attorney fees under that statute.

Claimant also argues that she is entitled to an attorney fee award under ORS 656.386(1), because her counsel was instrumental in "protecting" her award of compensation by persuading the employer to withdraw its request for hearing from the Order on Reconsideration.

Claimant misreads ORS 656.386(1). The language on which she relies applies only if an attorney is instrumental in "obtaining" compensation without a hearing. Because persuading the employer to withdraw its hearing request did not result in claimant's "obtaining" compensation without a hearing, Kim H. Harrison, 44 Van Natta 371 (1992), claimant is not entitled to an attorney fee award under ORS 656.386(1).

ORDER

The Referee's order dated May 26, 1993 is affirmed.

In the Matter of the Compensation of
LEONARD C. HOBBS, Claimant
WCB Case No. 92-14029
ORDER ON REVIEW
Parks & Ratliff, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Mongrain's order which upheld the insurer's denial of claimant's current left shoulder condition. In his brief, claimant argues that the Referee erred in not admitting Exhibits 22 and 24 (a medical report and chart notes from Dr. Balme, claimant's treating physician). On review, the issues are admission of evidence and compensability.

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

Claimant injured his left shoulder in May and December 1988 while working for a California employer. He filed a claim which was accepted and processed in California. In December 1991, claimant again injured his left shoulder, this time while employed by an Oregon employer. A prior referee set aside the insurer's denial of claimant's left shoulder injury claim.

Thereafter, shoulder surgery was considered. The insurer denied the surgery, stating that the 1991 Oregon injury was not the major contributing cause of the need for treatment. The Referee upheld the insurer's denial.

The Referee also declined to admit a medical report and chart notes from claimant's treating orthopedist, Dr. Balme. The Referee concluded that the exhibits were not relevant to the issue of causation because neither was specific as to which injuries (either the 1988 "out-of-state" injuries or the 1991 Oregon injury) the physician was addressing.

Compensability

Claimant argues that the insurer may not, at this time, avoid "responsibility" for claimant's shoulder surgery because it did not issue a disclaimer of responsibility pursuant to ORS 656.308(2) during the prior proceeding when its denial was set aside. The Referee concluded that ORS 656.005(7)(a)(B), rather than ORS 656.308, was applicable. We agree with the Referee.

To begin, because this "responsibility" dispute pertains to an "out-of-state" employer, we have serious doubts regarding the applicability of ORS 656.308. See ORS 656.005(25); 656.023; Progress Quarries v. Vaandering, 80 Or App 160 (1986). Furthermore, we recently stated in John I. Jett, 46 Van Natta 33 (1994) that an "out-of-state" employer would not appear to be subject to Oregon laws and, thus, ORS 656.308 would not apply in "responsibility" disputes pertaining to an "out-of-state" employer. See Miville v. SAIF, 76 Or App 603, 607 (1985) (Oregon can apply its own rules consistently between Oregon employers).

In any event, we need not resolve that question because the insurer denied "compensability" of the claim under ORS 656.005(7)(a)(B). Specifically, the insurer denied claimant's current disability and need for surgery, stating that the December 1991 injury was no longer the major contributing cause of the resultant disability and need for treatment. (Ex. 19). Inasmuch as the insurer is entitled to issue such a denial and since claimant has requested a hearing concerning that denial, we conclude that claimant has the burden of proving the compensability of his claim.

In this regard, there is no medical evidence suggesting that claimant's compensable injury is either a material contributing cause or the major contributing cause of his current left shoulder disability or need for treatment. The medical evidence shows that claimant's 1988 "out-of-state" shoulder injuries remained symptomatic, and that surgery was first recommended in 1989, although claimant chose not to proceed with surgery. (Exs. 8, 16-2). The original 1988 injuries caused a continuing laxity in claimant's shoulder which resulted in subsequent subluxations experienced in 1989 and 1991. (Ex. 17).

Both Dr. Balme and Dr. Woolpert, orthopedist, considered claimant's 1991 injury a recurrence of prior subluxations. (Exs. 10, 16-4). In light of these opinions, we conclude that claimant's "out-of-state" injuries and subluxations represent a "preexisting condition" under ORS 656.005(7)(a)(B). (Exs. 8, 10, 15-1, 16-5). See SAIF v. Drews, 318 Or 1 (1993) (ORS 656.005(7)(a)(B) is applicable regardless of whether a "preexisting condition" is compensable or noncompensable). Moreover, this medical evidence also establishes that this "preexisting condition" combined with claimant's Oregon injury. Thus, to prove the compensability of claimant's resultant disability, the record must establish that the December 1991 Oregon injury is the major contributing cause of his current disability or need for treatment. See ORS 656.005(7)(a)(B).

After conducting our de novo review, we agree with the Referee that the medical evidence is uncontroverted that claimant's December 1991 Oregon injury is not the major contributing cause of his current disability and need for surgery. Every physician, including claimant's treating doctor (Dr. Balme), attribute the need for surgery to claimant's original 1988 "out-of-state" injuries. Accordingly, we hold that the insurer's denial must be upheld.

Furthermore, even assuming that claimant must prove only that his December 1991 injury is a material contributing cause of his current disability and need for surgery, we are not persuaded that he has met this standard. As previously discussed, all of the medical opinions state that claimant's original 1988 injuries are the major contributing cause of his need for surgery. No physician attributes the need for surgery to the 1991 Oregon injury. Accordingly, claimant has failed to prove that the 1991 injury is even a material contributing cause of his need for surgery. Therefore, under either a material or major contributing cause standard, the insurer's denial would be upheld.

Because the excluded medical report and chart note from Dr. Balme did not differentiate between the "out-of-state" 1988 injury and the Oregon 1992 injury, we would reach these conclusions even if we considered the exhibits that the Referee declined to admit. Because admittance and consideration of this excluded evidence would not alter our decision, we decline to address claimant's contention that it was an abuse of discretion for the Referee to refuse to admit the disputed exhibits.

ORDER

The Referee's order dated March 18, 1993, as amended March 22, 1993, is affirmed.

In the Matter of the Compensation of
ALBERT H. OLSON, Claimant
WCB Case Nos. 92-08262 & 92-06785
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Westerband, Gunn and Haynes.

Freightliner Corporation (Freightliner) requests review of Referee Bethlahmy's order which: (1) set aside its denial of claimant's low back injury claim; and (2) upheld Consolidated Freightways' (CF) denial of claimant's medical services claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's January 20, 1992 injury with Freightliner was the major contributing cause of his disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his low back in 1974 while working for CF. He was diagnosed with possible spondylolisthesis. (Ex. 21-1). As a result of that injury, claimant underwent three surgeries (an L4-5 laminectomy and fusion extending from L4 to the sacrum in 1977, a refusion of the L4-5 level in 1978, and a second refusion at L4-5 in 1981). On January 20 and 21, 1992, while working for Freightliner, claimant performed work which was heavier than that to which he was restricted and, consequently, experienced increased low back and left leg and groin pain.

Claimant filed an "aggravation" claim with CF and a "new injury" claim with Freightliner. Following their denials, claimant requested a hearing. The Referee concluded that claimant had sustained a compensable injury on January 20, 1992 with Freightliner.[1] We agree.

Freightliner argues that claimant is not credible and did not suffer an injury on January 20 or 21, 1992. Claimant stated that on Monday and Tuesday (January 20 and 21, 1992) he performed heavy work on the axle rack because the employer was shorthanded. His back pain became so bad that he refused to perform the same work on Wednesday. Although we note that there are conflicting histories concerning the way claimant injured his back (Exs. 48, 52, 54), the record as a whole supports the occurrence of an injury on January 20, 1992. See Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, 56 Or App 184, 188 (1982) (injury is "sudden in onset" that is, occurring during a short, discrete period, rather than over a long period of time).

In July 1992, Dr. Smith, neurologist, performed surgery on claimant's back and reported that the major finding was an osteophyte at L3-4, compressing the L4 nerve root laterally. (Ex. 82). Smith stated that it was clear that the osteophyte was a preexisting condition relative to the January 1992 low back injury, and that the osteophyte combined with the injury, resulting in the left leg and groin pain. (Ex. 82).

Accordingly, claimant's resultant back condition is compensable if the January 20, 1992 injury is the major contributing cause of his disability and need for treatment. See ORS 656.005(7)(a)(B); SAIF v. Drews, 318 Or 1 (1993) (ORS 656.005(7)(a)(B) applicable regardless of whether a "preexisting condition" is compensable or noncompensable); Tektronix Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993). Furthermore, the resultant condition is compensable if claimant's work injury is the major contributing cause of a symptomatic worsening of his preexisting osteophyte, resulting in the need for surgery. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

With respect to causation of claimant's low back condition, Dr. Rosenbaum stated that the January 1992 work injury caused an "exacerbation without underlying pathologic change." Rosenbaum related claimant's current symptoms to his 1974 injury with CF because he noted that claimant had a history of chronic back and leg symptoms.

Dr. Smith disagreed, noting that claimant had not previously had groin pain, which is the distribution of the L4 nerve root, until the January 1992 injury, and that the injury caused the preexisting osteophyte to irritate the L4 nerve root. Smith stated that, in light of his surgical findings, the major reason for claimant's left leg and groin pain and need for surgery was the January 1992 injury with Freightliner. (Ex. 82). Dr. Avery agreed that claimant's injury exacerbated the quiescent osteophyte and that this exacerbation was the major contributing cause of the development of left groin pain. (Ex. 84-2).

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[1] Freightliner argues that CF did not issue a proper disclaimer and, thus, is precluded from arguing that Freightliner is responsible for claimant's condition. See ORS 656.308(2). We agree that failure to follow the requirements of ORS 656.308(2) precludes a carrier from arguing that another employment exposure caused a claimant's need for medical services. Byron E. Bayer, 44 Van Natta 1686, 1687 (1992). Here, however, we need not determine whether CF issued a proper disclaimer. One carrier's noncompliance with the disclaimer notice requirement of ORS 656.308(2) does not preclude the claimant from establishing the compensability of his claim against another carrier. Jon F. Wilson, 45 Van Natta 2362 (1993); Rachel J. Dressler-Iesalnieks, 45 Van Natta 1792 (1993). Since claimant has contended, and we have found, that he sustained a compensable injury while working for Freightliner, CF's alleged noncompliance with ORS 656.308(2) is of no consequence.

We conclude that Dr. Smith's opinion is persuasive. As the physician who performed claimant's back surgery, Smith is in the best position to provide an opinion regarding the cause of claimant's condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Furthermore, Dr. Avery, claimant's treating physician, agreed with Dr. Smith's opinion. Accordingly, we conclude that claimant has proven that he suffered an injury on January 20, 1992 which combined with the preexisting osteophyte, and that the injury is the major contributing cause of his resultant disability and need for treatment. ORS 656.005(7)(a)(B). Thus, Freightliner is responsible for claimant's current condition.

Claimant is entitled to an assessed attorney fee for services on 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 assessed attorney fee for claimant's counsel's services on review is $1,200, to be paid by Freightliner. 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 October 16, 1992, as corrected November 3, 1992, is affirmed. For services on Board review, claimant's attorney is awarded $1,200, to be paid by Freightliner.

Board Member Haynes dissenting:

I do not find persuasive evidence that claimant injured his back on or about January 20, 1992. Furthermore, even assuming claimant did suffer a new injury, the evidence does not show that claimant "sustained a new compensable injury involving the same condition," which is required in order to shift responsibility to the second employer, Freightliner. See ORS 656.308(1).

In order to apply ORS 656.308(1), claimant's current low back condition must involve the "same condition" as his 1974 low back strain with CF and the ensuing three surgeries (an L4-5 laminectomy and fusion extending from L4 to the sacrum in 1977, a refusion of the L4-5 level in 1978, and a second refusion at L4-5 in 1981). (Ex. 21). See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). Claimant's current low back condition involves an L3-4 osteophyte. (Ex. 82). Thus, based upon the following evidence, I would find that claimant's current low back condition is not the "same condition" as the 1974 injury.

Claimant injured his low back in 1974 while working for CF. He was diagnosed with possible spondylolisthesis. (Ex. 21-1). As a result of that injury, claimant underwent the three surgeries described above.

After an alleged January 20, 1992 injury while working for Freightliner, Dr. Smith, neurologist, performed surgery and reported that the major finding was an osteophyte at L3-4, compressing the L4 nerve root. (Ex. 82). Relying on the surgeon's opinion stating that the osteophyte was "indirectly" related to claimant's previous low back problems, I would conclude that claimant's current condition (L3-4 osteophyte) did not involve the same condition as the 1974 strain injury and ensuing L4-5 surgeries. See Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988). Therefore, ORS 656.308(1) is not applicable. See Smurfit Newsprint v. DeRossett, supra.

With respect to the issue of compensability, in order for claimant's current condition to be compensable as a consequence of his 1974 compensable low back injury with CF, claimant's injury must be the major contributing cause of the osteophyte condition. See ORS 656.005(7)(a)(A).

Dr. Lorish, electrodiagnostician, first examined claimant on February 7, 1992. (Ex. 48). Claimant reported that he began to have increased pain in his low back and leg about two years before. Then, over the past six months to a year, the pain in the low back was more severe and leg pain was increased. Further, claimant did not give Dr. Lorish a history of a work injury on January 20, 1992. Dr. Lorish attributed claimant's low back and leg pain to degenerative disease in the low back. He also related claimant's most recent pain to a radicular problem. (Ex. 67-2).

Dr. Rosenbaum, neurosurgeon, examined claimant on February 18, 1992. (Ex. 54). Claimant related an incident at work on January 20, 1992. Based on claimant's history of a recent work incident, Rosenbaum originally diagnosed a herniated disc at L3-4. Dr. Rosenbaum further noted that, if a disc herniation was subsequently confirmed, the January 1992 incident with Freightliner would be the major cause. On the other hand, if claimant's diagnosis became "more strain-like symptoms," Rosenbaum

would relate the diagnosis to a chronic condition dating back to claimant's prior injury. (Ex. 78-27, 28). As stated above, the condition was discovered to be an osteophyte at L3-4.

Dr. Avery, who had treated claimant before his 1992 work incident, stated that claimant's osteophyte was a preexisting condition that became painful after the January 20, 1992 incident. (Ex. 84-2). However, Avery concurred with Dr. Rosenbaum's conclusion that the incident represented an exacerbation of a preexisting osteophyte condition. (Ex. 81A).

Following the surgery, Dr. Rosenbaum received additional medical records indicating that claimant's condition was related to an osteophyte rather than a herniated disc. Rosenbaum then concluded that, because of claimant's history of chronic back and leg symptoms, his current condition was an exacerbation of his 1974 compensable injury, without a pathological worsening. (Ex. 79).

When the record is viewed as a whole, I am persuaded that the physicians' opinions support a conclusion that claimant's 1974 compensable injury was the major contributing cause of his current L3-4 disability and need for treatment. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Every physician who examined claimant related his current osteophyte condition to his 1974 back injury and surgeries. In essence, these physicians concluded that the fusion surgeries at L4 through the sacrum placed an extra strain on claimant's spine at L3-4. (Exs. 78-26, 82). This strain resulted in the L3-4 osteophyte.

For these reasons, I would conclude that claimant's current L3-4 osteophyte condition constitutes a consequential condition resulting from claimant's 1974 compensable injury with CF. Albany General Hospital v. Gasperino, supra. Accordingly, I dissent.

January 31, 1994 Cite as 46 Van Natta 175 (1994)

In the Matter of the Compensation of
CINDY A. SCHRADER, Claimant
WCB Case No. 92-15179
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Davis' order that: (1) found that claimant's aggravation claim for a bilateral carpal tunnel syndrome (CTS) was not prematurely closed; and (2) declined to assess penalties for allegedly unreasonable claim processing. The self-insured employer has moved for remand to the Referee for consideration of additional evidence which was generated subsequent to the Referee's order. This evidence consists of a medical report from a physician appointed by the Director under ORS 656.327 to address claimant's proposed right wrist surgery and the Director's subsequent order finding that the proposed surgery was not appropriate. On review, the issues are remand, premature closure, and penalties. We deny the motion to remand, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions and supplementation. We do not adopt the Referee's finding of ultimate fact.

On August 16, 1991, Referee Neal upheld the employer's December 20, 1990 denial of claimant's aggravation claim for her CTS. Claimant requested Board review of Referee Neal's order. On July 8, 1992, the Board reversed Referee Neal's order and set aside the employer's denial of the aggravation claim. In doing so, the Board found persuasive the opinions of Dr. Nash, claimant's treating neurosurgeon since 1987, and Dr. Grimm, consulting neurologist. (Ex. 40-2, -3). The Board found unpersuasive the opinions of examining physicians Drs. Button and Rosenbaum.

The employer requested reconsideration of the Board's July 8, 1992 Order on Review. On July 30, 1992, the Board issued an order denying reconsideration. (Ex. 37A). The employer did not appeal either of those Board orders.

On August 14, 1992, the employer's processing agent issued a Notice of Closure, declaring claimant medically stationary as of May 23, 1991, the date of Dr. Rosenbaum's report. (Exs. 35, 41).

On June 11, 1991, Dr. Grimm reasserted his opinion that claimant had a scar-induced neuroma as a result of the previous right CTS surgery that should be surgically removed. (Ex. 36).

On July 31, 1991, Dr. Nash reported that he had examined claimant on June 27, 1991, and that claimant's condition had worsened since he last examined her on November 14, 1990. (Ex. 38). Dr. Nash opined that claimant had bilateral CTS and bilateral carpal tunnel entrapment and recommended a surgical release of the median nerve entrapment. (Ex. 38-2).

On September 17, 1992, claimant returned to Dr. Nash for treatment. (Ex. 41a). Dr. Nash reported that claimant's condition had worsened since her last examination and that she was not medically stationary. (Exs. 41a, 41b).

Dr. Nash referred claimant to Dr. Long for electrodiagnostic testing, which was performed on October 19, 1992. (Ex. 41c). Dr. Long opined that the nerve studies did not show any convincing evidence of recurrent CTS. (Ex. 41c-3). However, Dr. Long diagnosed myofascial pain for which he recommended physical therapy that he opined would cure claimant's condition. Id.

Claimant requested reconsideration of the August 14, 1992 Notice of Closure. On November 5, 1992, the Appellate Unit set aside the Notice of Closure as premature. (Ex. 42).

The employer's processing agent's first request for information regarding claimant's medically stationary status was sought from Dr. Radecki, examining physician, who examined claimant on December 8, 1992. (Ex. 44).

CONCLUSIONS OF LAW AND OPINION

Remand

The employer has moved for remand to the Referee for consideration of a medical report from Dr. Tanabe, a physician appointed by the Director under ORS 656.327 to address claimant's proposed right wrist surgery, as well as the Director's subsequent order finding that the proposed surgery was not appropriate. Both of these proposed exhibits were generated after the Referee's order was issued.

Regarding the Director's order, 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 the Director's order meets the aforementioned standard, we take administrative notice of it.

However, the Director's order does not address claimant's medically stationary status at claim closure, which is the relevant issue here. In addition, the order relies, in large part, on medical opinions that the Board has previously found unpersuasive. Therefore, although we take administrative notice of the Director's order, we do not find it persuasive evidence regarding the issue of whether claimant was medically stationary at claim closure.

Regarding Dr. Tanabe's report, 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 was not obtainable at the time of hearing and 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). We examine the proposed exhibit only to determine if remand would be appropriate.

Here, Dr. Tanabe's report presents his opinion regarding claimant's current condition and whether surgery is appropriate for that condition. Although Dr. Tanabe's opinion was not available at hearing, the employer has not established that such an opinion from Dr. Tanabe or of any number of other doctors regarding these matters could not have been obtained with the exercise of due diligence at the time of hearing. The issue is not Dr. Tanabe's title as a medical arbiter under ORS 656.327, it is whether he presents a medical opinion that could have been obtained with due diligence at the time of hearing.

In any event, Dr. Tanabe's opinion is not reasonably likely to affect the outcome of this case. As discussed below, at the time claimant's claim was closed, there is no evidence in the record that claimant was medically stationary. Any subsequent analysis of a later surgery request does not change that fact. Therefore, we conclude that there is not a compelling reason to justify remanding this case to the Referee for the taking of further evidence. Consequently, the motion to remand is denied.

Premature Closure

The Referee affirmed the August 14, 1992 Notice of Closure, finding that claimant's condition was medically stationary when her claim was closed. We disagree and find that claimant's claim was prematurely closed by the August 14, 1992 Notice of Closure.

"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 addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Claimant bears the burden of proving that she was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

In determining medically stationary status, OAR 436-30-035(1) provides that 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." Here, at the time of claim closure, there was no medical opinion indicating that claimant was medically stationary.

On July 8, 1992, the Board issued an order that reversed a prior referee's order that had found that claimant's compensable bilateral CTS condition had not worsened. In making that determination, the Board found the opinions of Dr. Button, examining surgeon, and Dr. Rosenbaum, examining surgeon, unpersuasive and concluded that claimant had established a compensable aggravation claim. (Ex. 40). The employer requested reconsideration of that order. However, on July 30, 1992, the Board issued an order denying reconsideration. (Ex. 37A). The employer did not appeal either of those Board orders.

Two weeks later, on August 14, 1992, the employer's processing agent issued a Notice of Closure closing claimant's claim and indicating that claimant's condition was medically stationary as of May 23, 1991, the date of Dr. Rosenbaum's report. (Exs. 35, 41).

However, although Dr. Rosenbaum advised against repeat carpal tunnel surgery for claimant, he did not address the issue of whether claimant's compensable condition was medically stationary. (Ex. 35). In fact, Dr. Rosenbaum recommended further treatment in the form of an occupational therapy program or a work hardening program, although he did not indicate that such treatment would be expected to result in material improvement in claimant's condition. (Ex. 35-6).

In any event, the question that Dr. Rosenbaum addressed in his May 23, 1991 report was not whether claimant's condition was medically stationary but whether her condition had worsened. (Ex. 35-5). Although those questions are not mutually exclusive, the important point is that Dr. Rosenbaum did not address the question of whether claimant was medically stationary.

Regarding the question of whether claimant's condition had worsened, Dr. Rosenbaum opined that claimant was no worse than she was at the time of her last arrangement of compensation on March 10, 1990. Id. In its July 8, 1992 order, the Board found that opinion unpersuasive. (Ex. 40-2). However, the Board found that Rosenbaum's opinion that claimant's history and symptoms supported a diagnosis of recurrent symptoms of bilateral CTS was essentially consistent with the opinions of Drs. Nash, treating surgeon, and Grimm, consulting physician. In addition, the Board found that Dr. Rosenbaum conceded that a mild CTS might exist even without objective abnormalities. (Ex. 35-5, 40-2).

On June 11, 1991, Dr. Grimm reasserted his opinion that claimant had a scar-induced neuroma as a result of the previous right CTS surgery that should be surgically removed. (Ex. 36).

On July 24, 1991, Dr. Nash reexamined claimant and concluded that claimant's compensable condition had worsened and that she had bilateral carpal tunnel entrapment. Dr. Nash recommended surgical release of the median nerve. (Ex. 38-2). Thus, at the time of claim closure, both Drs. Nash and Grimm essentially opined that claimant was not medically stationary in that she required surgical treatment for her compensable condition.

Furthermore, after the August 14, 1992 Notice of Closure, on September 21, 1992, Dr. Nash listed claimant's neurologic findings and concluded that she was not medically stationary. (Exs. 41a, 41b, 45). Finally, based on a December 4, 1992 MRI and claimant's ongoing neurologic findings, Dr. Nash recommended surgical release of the right median nerve. (Ex. 45).

Dr. Radecki examined claimant on December 8, 1992 and performed a record review. He opined that claimant remained medically stationary since May 13, 1991, the date of Dr. Rosenbaum's examination of claimant. (Ex. 44). Dr. Radecki's opinion was based on claimant's "excellent" responses to electrodiagnostic testing and on the opinion of Dr. Button that claimant's complaints were attributed to functional overlay. Furthermore, Dr. Radecki doubted that claimant ever had bilateral CTS and opined that claimant's condition had not changed since her prior closure.

However, it is the law of the case that claimant has a compensable bilateral CTS condition that has worsened since the last arrangement of compensation. (Exs. 21, 28, 40). Kuhn v. SAIF, 73 Or App 768 (1985). In addition, the Board previously found Dr. Button's opinion regarding functional overlay causation to be unpersuasive. (Ex. 40-2). In light of such circumstances, we find Dr. Radecki's reasoning unpersuasive.

The employer argues that the opinions of Drs. Button and Rosenbaum do not support a premature closure finding. However, Dr. Button's opinion regarding functional overlay causation has been rejected by the Board. Furthermore, contrary to the employer's assertions, Dr. Rosenbaum did not address the medically stationary issue.

In addition, an MRI was performed on December 4, 1992 by Dr. Adamson who noted that the flattening of the right median nerve was "particularly interesting" and recommended clinical correlation for further evaluation of those findings. (Ex. 43-2). Dr. Nash is the only physician to evaluate the MRI in relationship to claimant's clinical findings. (Ex. 45-1). He found that the MRI findings in conjunction with claimant's ongoing neurologic findings supported a surgical release of claimant's right median nerve. Id. There is no indication that Dr. Radecki evaluated the MRI.

The employer also argues that Dr. Nash's opinion regarding claimant's medically stationary status is unpersuasive given the normal nerve conduction tests performed by Drs. Rosenbaum, Long, and Radecki. Yet, Dr. Grimm also performed nerve conduction studies, which he found were not normal and represented bilateral entrapment syndrome of the median nerves. (Ex. 33-2). Much is made about the fact that Dr. Grimm did not warm claimant's hands before testing them. However, in interpreting his test results, Dr. Grimm indicated that the degree of conduction delay across the carpal tunnels could not be accounted for by claimant's "slightly cool" hands. (Ex. 33-2). In addition, Dr. Grimm noted that this "technical matter" was not crucial in that Dr. Rosenbaum accepted the possibility that a mild, recurrent CTS could occur following surgery and could present without losses in conduction measurement. (Ex. 36-1). As noted above, in its prior order, the Board found that Dr. Rosenbaum had conceded that a mild CTS might exist even without objective abnormalities. (Ex. 35-5, 40-2).

In any event, although Dr. Long opined that there was no electrodiagnostic evidence that claimant has recurrent CTS, he recommended physical therapy which he concluded would cure claimant's symptoms which he considered were myofascial rather than neurologic. (Ex. 41c-3).

Finally, the employer argues that Dr. Nash does not explain his change in recommended treatment from bilateral CTS surgery in July 1991 to a more limited request for a right median nerve release in December 1992. (Exs. 38, 45). However, because claimant has a compensable bilateral CTS condition, further recommended treatment that is limited to the right hand is sufficient to establish that claimant was not medically stationary. In any event, Dr. Nash tied the change in the recommended treatment to the recent MRI that was not available at the time of his July 1991 recommendation. (Ex. 45).

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 rely on the opinion of Dr. Nash. Accordingly, we conclude that claimant was not medically stationary at the time her claim was closed.

Penalties and Attorney Fees

Because he found the August 14, 1992 Notice of Closure appropriate, the Referee rejected claimant's assertions regarding entitlement to penalties and attorney fees based on the alleged inappropriateness of the closure and awarded no penalties or fees. We disagree that the closure was appropriate and address the penalty issue.

Claimant argues that she is entitled to a penalty and an attorney fee pursuant to ORS 656.268(4)(f), alleging that the employer's closure of her claim was unreasonable. We agree that the employer's claim closure was unreasonable and find that claimant is entitled to a penalty pursuant to ORS 656.268(4)(f). However, the clear language of the statute provides only for a penalty, which is to be "paid to the worker." No provision is made for an attorney fee under ORS 656.268(4)(f).

ORS 656.268(4)(f) provides:

> "If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this subsection, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, 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." (Emphasis added).

The reasonableness of a carrier's actions must be gauged based upon the information available to the carrier at the time of its action. Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, the employer's claims processor closed the claim two weeks from the date of the Board's prior order, which had found that claimant had established a compensable aggravation claim based on the the persuasive opinions of Drs. Nash and Grimm. If justified, that claim closure would be permissible. Here, the record did not justify it.

At the time the employer's claims processor issued the Notice of Closure, the medical evidence from Drs. Nash and Grimm indicated that claimant's compensable condition required further treatment. In addition, although the employer's claims processor apparently relied on the report from Dr. Rosenbaum to assign a medically stationary date, that report did not address claimant's medically stationary status. Furthermore, the Board had previously found Dr. Button's opinion regarding functional overlay causation unpersuasive.

Therefore, there was no persuasive medical opinion that claimant was medically stationary at the time her claim was closed on August 14, 1992. The employer's claims processor first sought a medical opinion regarding claimant's medically stationary status when it requested Dr. Radecki's opinion, which was not issued until December 8, 1992, almost four months after claimant's claim had been closed and approximately one month after the Appellate Unit had set the Notice of Closure aside as premature.

Under these circumstances, the employer had no reasonable basis for declaring claimant medically stationary and closing the claim. Therefore, we find that the Notice of Closure was not reasonable and assess a penalty of 25 percent of all compensation then due at the time of hearing as a result of this order, to be paid to claimant. ORS 656.268(4)(f); cf. Dominic R. Gordon, 42 Van Natta 2487 (1990) (found closure unreasonable and assessed a penalty of 25 percent of "all compensation determined to be then due at the time of hearing," applying former ORS 656.268(3)(f), which is currently found at ORS 656.268(4)(f), and is identical to the current version of the statute except that the 1990 amendments deleted the provision of a minimum penalty of $1,000).

Claimant also argues that she is entitled to a penalty pursuant to ORS 656.262(10) for the employer's unreasonable delay or refusal to pay compensation. We agree that the employer unreasonably resisted payment of compensation. However, we are unable to assess a penalty under ORS 656.262(10). Nevertheless, as discussed below, claimant is entitled to an assessed attorney fee pursuant to ORS 656.382(1) for the employer's unreasonable resistance to the payment of compensation.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10).

In addition to unreasonably closing claimant's claim, the employer also improperly unilaterally terminated claimant's temporary disability compensation. We note that the Board can award a separate attorney fee for separate unreasonable conduct that relates to a different factual basis. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

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); Steven S. Ewen, 45 Van Natta 207 (1993).

Following a July 24, 1991 examination, Dr. Nash, claimant's attending physician, authorized time loss from November 14, 1990 through the date of the examination. (Ex. 38). Following Dr. Nash's authorization of temporary total disability, none of the events listed in ORS 656.268(3) occurred that would have enabled the employer to unilaterally terminate the temporary disability. In addition, on September 21, 1992, Dr. Nash restated that claimant should be receiving time loss benefits. (Ex. 41b).

On July 8, 1992, when the Board previously found claimant's aggravation claim compensable, it directed the employer to process the claim according to law. (Ex. 40). On July 30, 1992, the Board denied the employer's request to reconsider our earlier order. On August 14, 1992, rather than paying claimant the temporary total disability authorized by Dr. Nash, the employer, in effect, unilaterally terminated claimant's temporary disability before commencing to pay the benefits without any of the conditions under ORS 656.268(3) having been met. Under the circumstances, we find that the employer's conduct constituted an unreasonable refusal to pay compensation and subjects the employer to the assessment of a penalty under ORS 656.262(10).

However, we have already assessed a penalty of 25 percent of all amounts then due at the date of hearing, and there is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. Robert A. Brooks, Jr., 44 Van Natta 1105 (1992); Mollie E. Barrow, 43 Van Natta 617 (1991). On the other hand, there is authority for awarding an attorney fee for unreasonable resistance to the payment of compensation, regardless of whether any penalty may be assessed. ORS 656.382(1); Mollie E. Barrow, supra.

Accordingly, after considering the factors set forth in OAR 438-15-010(4), we award an attorney fee of $2,500 for the employer's unreasonable resistance to the payment of compensation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's attorney's briefs), the complexity of the issue, and the value of the interest involved. ORS 656.382(1); OAR 438-15-010(4).

Finally, claimant argues that she is entitled to a penalty for the employer's allegedly unreasonable request for a hearing following the Department's Order on Reconsideration, which found that the claim was prematurely closed. Claimant is not entitled to a penalty on that basis because the employer had a right to seek review of the Order on Reconsideration which set aside its Notice of Closure. ORS 656.268(6)(b).

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 May 25, 1993 is reversed in part and affirmed in part. The August 14, 1992 Notice of Closure is set aside as premature. The claim is remanded to the self-insured employer for further processing according to law. The employer is assessed a penalty pursuant to ORS 656.268(4)(f) equal to 25 percent of the amounts then due as of the February 12, 1993 hearing as a result of this order, to be paid to claimant. The employer is also assessed a penalty-related attorney fee of $2,500 under ORS 656.382(1) for the employer's unreasonable unilateral termination of temporary total disability benefits, to be paid directly to claimant's attorney. Claimant's attorney is awarded 25 percent of the increased temporary disability benefits 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.

In the Matter of the Compensation of
PAULINE TAYLOR, Claimant
WCB Case No. 93-05984
ORDER OF DISMISSAL
Lundeen, et al., Defense Attorneys

Claimant, pro se, has requested Board review of Referee Menashe's October 8, 1993 order. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that notice of claimant's request was not timely provided to the other parties, we dismiss.

FINDINGS OF FACT

The Referee's Opinion and Order issued October 8, 1993. On Monday, November 8, 1993, the Board received claimant's request for Board review of the Referee's order. The request did not indicate that copies had been provided to the parties.

On November 9, 1993, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review. The employer's and its insurer's receipt of that acknowledgment constitutes their first notice of the request for review.

ULTIMATE FINDINGS

Claimant's request for review was received by the Board within 30 days of the Referee's order. However, the other parties to the proceeding did not receive notice of the request within 30 days of the Referee's order.

CONCLUSION OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's October 8, 1993 order was November 7, 1993, a Sunday. Consequently, the final day to perfect an appeal from the Referee's order was Monday, November 8, 1993. Anita L. Clifton, 43 Van Natta 1921 (1991). Since claimant's request was received by the Board on November 8, 1993, it is timely.

Nevertheless, claimant's request for review does not indicate 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 other parties' first notice of claimant's appeal occurred when they received the Board's November 9, 1993 acknowledgment letter.

Inasmuch as November 9, 1993 is more than 30 days from the date of the Referee's October 7, 1993 order, we are persuaded that the other parties to this proceeding did not receive timely notice of claimant's request for Board review.[1] Because the request is untimely, we lack authority to review the Referee's order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In the event that claimant can establish that she provided notice of her appeal to the other parties (the employer and its insurer) on or before November 8, 1993, she may submit such information for our review. However, to be considered, such information must be received in sufficient time to permit us to withdraw this order for reconsideration. Since our authority to reconsider this order expires within 30 days from the date of this order, claimant must respond in an expeditious manner.

In the Matter of the Compensation of
CATHERINE WASHBURN, Claimant
WCB Case No. TP-93012
THIRD PARTY DISTRIBUTION ORDER ON RECONSIDERATION
Paulson & Baisch, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Claimant has requested reconsideration of our January 14, 1994 Third Party Distribution Order which approved a proposed third party compromise and directed distribution of the proceeds in accordance with ORS 656.593(3). Contending that she has prevailed against GAB Business Services' "frivolous appeal," claimant seeks a carrier-paid attorney fee award.

We deny claimant's request. To begin, we are without statutory authority to assess a penalty for a frivolous appeal. See Verl E. Smith, 43 Van Natta 1107 (1991). In any event, this case does not arise from an appeal from a referee's decision. Rather, this third party settlement dispute was presented for our resolution under ORS 656.587 and ORS 656.593(3). We have previously held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. Theresa J. Lester, 43 Van Natta 338 (1991).

Accordingly, we withdraw our January 14, 1994 order. On reconsideration, as supplemented herein, we republish our January 14, 1994 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
DANNY L. WEDGE, Claimant
WCB Case No. 93-02797
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of that portion of Referee Hoguet's order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of each wrist, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of scheduled permanent disability.

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

Claimant must prove at least a partial loss of ability to repetitively use his wrists. Donald E. Lowry, 45 Van Natta 1452 (1993). The employer contends that the Referee's 5 percent "chronic condition" awards for each of claimant's wrists were incorrect because there is no medical evidence that claimant has a "chronic condition" in his wrists. We agree with the Referee that the record as a whole supports a finding that claimant is entitled to chronic condition awards for each wrist. Accordingly, claimant has carried his burden of proof.

We also note that the employer's own worksheet indicates that claimant's scheduled awards in the Notice of Closure were given for "bilateral chronic conditions limiting repetitive use." (Ex. 19). Although the employer now contends that the medical evidence prior to the Notice of Closure, particularly from Dr. Rabie, claimant's attending physician, does not establish the chronic conditions, it apparently found that evidence sufficient to award claimant permanent disability in the Notice of Closure. Moreover, we note Dr. Rabie's comment that claimant should not only avoid vibrational tools but also "any significant heavy repetitive use of his hands." (Ex. 16). We agree with the Referee that the only subsequent medical evidence, Dr. Dinneen's medical arbiter's report which stated that claimant does not have a chronic condition, is conclusory and therefore entitled to little weight.

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

ORDER

The Referee's order dated June 16, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $600, to be paid by the self-insured employer.

In the Matter of the Compensation of
PENNY L. HAMRICK, Claimant
WCB Case Nos. 92-13017 & 92-04669
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys
Neil W. Jones, Defense Attorney

Fireman's Fund Insurance Company requests reconsideration of our January 5, 1994 Order on Review that affirmed a referee's order which set aside Fireman's denial of claimant's occupational disease claim for a right elbow condition and upheld Safeco Insurance Company's denial of claimant's claim for the same condition. Disagreeing with the "responsibility/disclaimer" portion of our order, Fireman's contends that, due to Safeco's failure to properly disclaim responsibility, Safeco is precluded from arguing that claimant's employment exposure with Fireman's insured caused her disability or need for treatment.

In order to consider Fireman's contentions, and to allow the other parties an opportunity to respond, we withdraw our January 5, 1994 Order on Review. We implement the following supplemental briefing schedule.

Supplemental responses from claimant and Safeco shall be filed within 14 days from the date of this order. Fireman's supplemental reply shall be due within 14 days from the date of mailing of the supplemental responses filed by claimant and Safeco.

In submitting their respective positions, the parties are requested to address the effect, if any, the following holdings have on this dispute: Jon F. Wilson, 45 Van Natta 2362 (1993); Rachel J. Dressler-Iesalnieks, 45 Van Natta 1792 (1993); and Timm v. Maley, 125 Or App 396 (1993). Following expiration of the supplemental briefing schedule, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUGENE E. KELLUM, Claimant
WCB Case No. 93-01467
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Referee Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for a neck and right shoulder condition; and (2) awarded an assessed fee of $4,000 to claimant's attorney for services at hearing. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant worked for the employer, a temporary service agency, at Northwest Cutstock. Claimant operated a rip saw, feeding wood into the machine and stacking the wood after it was cut. On October 3 and 4, 1992, claimant and his household moved into a different house. On October 12, 1992, claimant sought treatment for neck and right shoulder symptoms. The Referee found that claimant's work, and not the moving activity, caused claimant's condition; in reaching this conclusion, the Referee found that the testimony of three witnesses called by the employer was unreliable or inaccurate. On review, the employer first challenges the Referee's analysis of the testimony.

At hearing, claimant testified that, shortly after starting work at Northwest Cutstock, he began experiencing pain in his right shoulder and arm that gradually worsened. (Tr. 10-11). Claimant further stated that his symptoms were present before moving and that the move had little effect on his condition. (Id. at 11-13).

Claimant's testimony was corroborated by Matthew Tift, a coworker at Northwest Cutstock, and Kim Socha, a friend and neighbor. Tift testified that, before moving, claimant complained about neck and shoulder pain. (Id. at 65-66). Tift also stated that claimant did not relate his condition to work and that the move aggravated his symptoms. (Id. at 66, 73). Socha helped claimant move, testifying that she did so because claimant's neck and shoulder were sore from working. (Id. at 81).

There also was testimony from Vince Dill, claimant's immediate supervisor at Northwest Cutstock, that he had witnessed claimant in pain at work for the first time after he had moved. (Id. at 50, 56). Rodney Miller, principal shareholder and manager of Northwest Cutstock, testified that claimant approached him when Miller arrived at work, telling Miller that he had hurt his neck and shoulder while moving over the weekend and that he was unable to work the entire day. (Id. at 102). Miller subsequently explained that he thought this event occurred on October 5, 1992 based on a timesheet that he and his secretary reconstructed in late October 1992. (Id. at 111, 115).

Elaine Guard, the employer's manager, testified that, while claimant was in the employer's office on October 12, 1992, he rubbed his shoulder and, in response to questions about the condition of his shoulder, stated that he had hurt his shoulder over the weekend while moving. (Id. at 124). With regard to the same event, Nancy Bodine, the employer's workers' compensation claims supervisor, testified that claimant first responded that he was "not sure" what had happened to his shoulder and that he thought it may have been injured while moving. (Id. at 136-37).

The Referee found the testimony of Miller and Bodine to be "unreliable" and that Guard was "mistaken." We disagree. First, we note that the Referee's credibility findings were based on her findings of inconsistency rather than demeanor. Consequently, because the Referee's findings were based on the substance of the testimony, she had no greater advantage in determining credibility than the Board. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Having reviewed the record, we find the testimony of Miller, Guard, and Bodine to be credible. In particular, we disagree that Miller's testimony was entirely based on the "reconstructed" time sheet; rather, his testimony shows that he had an independent recollection of his conversation with claimant and that he relied on the document only when stating that the event occurred on October 5, 1992. Furthermore, we find that any reliance by Miller on the "reconstructed" time sheet did not render his testimony unreliable since the document was prepared a short time after the event.

Furthermore, we find that Bodine's testimony was not inconsistent with the fact that the employer paid for claimant's initial treatment and provided light duty since she testified that a person with a nonwork-related injury would receive the same treatment. Furthermore, Bodine explained that it was the employer's policy to repeat a claimant's explanation of a work injury on the 801 form and, consequently, she did not relate the October 12, 1992 conversation on the 801.

Although we have found the testimony of Miller, Guard, and Bodine to be credible, we do not find that such testimony defeats the claim. At most, such testimony shows that claimant stated that he told them that he thought he injured his shoulder during the move. Such evidence is not necessarily inconsistent with his testimony that he began having symptoms prior to the move. Furthermore, claimant presented evidence corroborating his testimony, including the testimony of Tift and Socha and the documentary evidence. The history taken by Meisel, the physician's assistant who treated claimant, was that claimant began noticing a "gradual dull aching sensation at work" in late September 1992, and that he moved without noticing any significant change until a few days prior to the examination, when he experienced significant pain. (Ex. 2). Claimant provided essentially the same history when he sought treatment at the emergency room and with Dr. Carter, an orthopedic surgeon. (Exs. 14, 16, 18). In short, we find that the record contains a preponderance of evidence showing that claimant began experiencing symptoms prior to the move and that his symptoms worsened after the move.

The employer further asserts that claimant failed to prove compensability because the only opinion proving causation is from Dr. Lorenz, internal medicine specialist, who never examined or treated claimant. Dr. Lorenz, finding that the clinic notes of Meisel and Dr. Carter were consistent with the "onset of injury two months after starting work as a rip-saw operator, stated that there was "no doubt that [claimant] has suffered medical injury on the basis of work." (Ex. 27).

We disagree that, because Dr. Lorenz did not examine claimant, his opinion lacks probative value with regard to causation since Dr. Lorenz based his opinion on medical providers who did examine and treat claimant. Meisel and Dr. Carter provided accurate histories of claimant's condition. Consequently, we find no basis for rejecting Dr. Lorenz's opinion as unreliable. Furthermore, there is no contrary medical evidence. Thus, we conclude that claimant proved compensability. See ORS 656.802(2).

Attorney Fees

Finally, the Referee awarded claimant's attorney a carrier-paid fee of $4,000 under ORS 656.386(1) for prevailing against the employer's denial. Contending that the Referee's award was excessive, the employer seeks a reduction of that award. We find the Referee's attorney fee award to be reasonable.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $4,000 is a reasonable fee for claimant's counsel's services at the hearing level regarding the denial issue. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Claimant is also entitled to an assessed attorney fee for services on review regarding the compensability issue. ORS 656.382(2). After considering all of the factors recited in the aforementioned administrative rule, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,200, 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 counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review devoted to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 1, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, payable by the employer.

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case No. 93-00581
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Scott H. Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Referee Menashe's order that: (1) directed it to pay additional temporary total disability; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties.

We affirm and adopt the Referee's order with the following supplementation concerning the temporary disability issue.

Claimant compensably injured her lumbar and cervical spine on November 7, 1985. An August 1, 1988 Determination Order awarded her temporary disability from December 17, 1987 to June 1, 1988 and 23 percent unscheduled permanent disability. The permanent disability award was later raised to 45 percent by a prior referee's order.

On February 21, 1989, claimant began an authorized training program (ATP). The ATP and vocational assistance were terminated on March 26, 1990 due to claimant's failure to cooperate. On May 16, 1990, claimant's attending physician found her lumbar and cervical conditions medically stationary.

Claimant had begun treatment with psychologist, Dr. Fleming, in October 1989. On July 17, 1990, the employer denied claimant's psychological condition.

On July 26, 1990, a Determination Order issued. Noting that claimant had not completed her ATP, the Determination Order awarded temporary disability from February 21, 1989 through February 28, 1989 and April 11, 1989 through May 16, 1990. The Determination Order declared claimant medically stationary on June 1, 1988, not medically stationary on May 12, 1989 and medically stationary again on May 16, 1990.

The employer had stopped payment of temporary disability on March 29, 1990 when the ATP was terminated. Following the Determination Order, the employer paid claimant temporary disability through May 16, 1990 (her medically stationary date).

Claimant requested a hearing concerning the denial of her psychological condition and the July 26, 1990 Determination Order. On January 27, 1992, a prior referee upheld the denial of claimant's psychological condition and found that the claim had not been prematurely closed. The prior referee also declined to award further permanent disability or penalties.

Claimant requested review of the prior referee's order. On November 17, 1992, we reversed the prior referee's order and found the psychological condition compensable. Mary J. McKenzie, 44 Van Natta 2302 (1992). Concluding that claimant's psychological condition was not medically stationary on the date of closure, we set aside the July 26, 1990 Determination Order as premature. Id. The employer appealed the November 17, 1992 order and the court subsequently affirmed without opinion. 121 Or App 686 (1993).

The employer has not paid any temporary disability since the November 17, 1992 Order on Review. Objecting to the employer's claim processing conduct, claimant requested a hearing.

The Referee ordered the employer to pay temporary disability benefits from November 17, 1992 (the date of the prior Board's order) and continuing thereafter until such benefits could be terminated as authorized by law. In reaching this decision, the Referee reasoned that the effect of the Board's November 17, 1992 order setting aside the July 26, 1990 Determination Order, was that the claim was in open status. Since none of the "unilateral termination" conditions contained in ORS 656.268(3) had occurred since the July 1990 Determination Order, the Referee concluded that the employer was required to pay temporary disability commencing as of the date of the Board's November 17, 1992 order.

On review, the employer raises several arguments. First, it contends that claimant's claim was open for an ATP. On this basis, the employer argues that ORS 656.268(8) governs claimant's entitlement to temporary disability rather than ORS 656.268(3).

ORS 656.268(8) provides, in relevant part: " . . . When the worker ceases to be enrolled and actively engaged in the training, the Department . . . shall reconsider the claim pursuant to this section unless the worker's condition is not medically stationary . . ." (Emphasis added). In addition, OAR 436-120-230(2) provides, in part, that temporary disability shall continue pending a subsequent determination under ORS 656.268 unless the worker has returned to regular employment. As previously noted, the Determination Order has been set aside on the grounds that claimant's compensable psychological condition was not medically stationary on the date of closure. Thus, although the claim was originally open for the ATP, its eventual closure was set aside because claimant's compensable psychological condition was not medically stationary. In other words, it has been conclusively determined that the prior closure of the claim was improper. Since the claim was reopened as a result of our order, the employer was obligated to process claimant's claim in accordance with law. Because claimant was neither released to regular work nor had she returned to regular work, the employer was not authorized to terminate temporary disability.

The employer further contends that pursuant to ORS 656.340(12), claimant was only entitled to a maximum of 16 months of temporary disability benefits . We find the statute to be inapplicable.

Pursuant to ORS 656.340(12), a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months, subject to extension to 21 months by order of the Director if good cause is shown. However, the limitations on temporary disability contained in ORS 656.340(12) only pertain to temporary disability during the training program. In this case, the training program had been terminated and the claim was open because of our prior order which found the claim prematurely closed and set aside the Determination Order. Thus, the limitations contained in ORS 656.340(12) do not apply since the claim was no longer open for the training program.

The employer next contends that it did not have to pay temporary disability benefits upon issuance of our November 1992 order because no physician authorized time loss in relation to claimant's psychological condition. We disagree.

The employer stopped paying temporary disability after the ATP was terminated. In response to the July 1990 Determination Order, the employer paid temporary disability until May 1990 (when Dr. Berkeley found claimant medically stationary). Therefore, when the July 26, 1990 Determination Order was set aside, the employer was required to resume paying the temporary disability it had stopped paying in May 1990 until one of the events specified in ORS 656.268(3) occurred.

The employer argues that the psychological condition was a "new" facet of the claim. On this basis, the employer argues that there is not a continuing obligation to pay temporary disability. Again, we disagree. The psychological condition is not a new condition, but rather is a compensable consequence of the injury claim. The Determination Order closing the injury claim was set aside because one of the compensable conditions caused by the injury, the psychological condition, was not yet medically stationary. Thus, we do not agree that claimant's entitlement to temporary disability benefits for the psychological condition must be re-analyzed as a new period of the claim.

The employer next contends that claimant has withdrawn from the work force. We disagree. The critical time for determining whether a claimant has "withdrawn" from the work force is at the time of her disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990). Here, claimant was disabled at the time her claim was reopened for the ATP. Thus, claimant has not withdrawn from the work force and was willing to work and participating in vocational training at the critical time.

Finally, the employer notes that the claim has subsequently been closed by a May 7, 1993 Determination Order, which awarded temporary disability from February 21, 1989 through February 28, 1989 and from April 11, 1989 to August 7, 1990. Consequently, the employer argues that claimant is not substantively entitled to the temporary disability benefits ordered payable by the Referee.

In Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the court held that we lacked authority to impose an "administrative" overpayment of temporary disability benefits when the claimant was not substantively entitled to such benefits. However, we have subsequently held that benefits paid pending appeal pursuant to ORS 656.313(1)(a)(A) do not constitute a "procedural overpayment." Rather, we have reasoned that ORS 656.313(1)(a)(A) creates a statutory obligation to pay temporary disability compensation awarded by an appealed order. Lela K. Mead-Johnson, 45 Van Natta 1754(1993); John R. Heath, 45 Van Natta 466, on recon 45 Van Natta 840 (1993). Accordingly, the employer had a statutory duty to pay temporary disability benefits from the date of the Board's November 17, 1992 order until the claim was closed on May 7, 1993.

When the employer appealed the Board's November 17, 1992 order, the compensation appealed from was stayed, except temporary disability benefits that accrued from the date of the order appealed from until closure, or until the order was reversed, whichever event occurs first. ORS 656.313(1)(a)(A); Lela K. Mead-Johnson, supra; Steven S. Ewen, 45 Van Natta 207, on recon 45 Van Natta 425 (1993). Here, the employer was obligated to make temporary disability payments until the claim was closed on May 7, 1993.

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 $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 issues, 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 May 4, 1993 is affirmed. For services on review, claimant's attorney is awarded $750 payable by the employer.

February 2, 1994 Cite as 46 Van Natta 189 (1994)

In the Matter of the Compensation of
TERRY D. WAIBEL, Claimant
WCB Case Nos. 92-06196 & 92-06035
ORDER ON REVIEW
Angelo Gomez, Claimant Attorney
James D. Booth (Saif), Defense Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee Nielsen's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for an asthma condition; and (2) declined to award a penalty and related attorney fee for an allegedly unreasonable denial of claimant's current condition. On review, the issues are aggravation and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant has an accepted claim for Western Red Cedar asthma as a result of working for Stimpson's Lumber, insured by SAIF. Claimant has received a total of 47.5 percent unscheduled

permanent disability. In October 1989, claimant began working as a manager at Pizza Hut, insured by Hartford Insurance Corporation. In January 1992, he left his manager job and filed an aggravation claim for his asthma condition.

The Referee set aside SAIF's denial of claimant's current condition claim, finding that claimant's symptoms were in major part due to his accepted asthma condition. The Referee further found that SAIF, and not the Hartford, was responsible for claimant's current condition. However, the Referee concluded that claimant failed to prove a compensable aggravation of his asthma condition.

In order to prove 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). Finally, because claimant received a previous permanent disability award for his condition, he must establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

The record shows that claimant experienced increased symptoms while working at Pizza Hut. Dr. Ironside, claimant's treating physician and pulmonary specialist, Dr. Montanaro, occupational asthma specialist who examined claimant on behalf of the Hartford, and Drs. Pappas and Barnhart, occupational medicine specialists who examined claimant upon his attorney's referral, all indicated that claimant's asthma condition exacerbated and that he had an increase in symptoms. (Exs. 112, 126-5, 141, 141A-22, 146-13).

Furthermore, we find that the increased symptoms resulted in a diminished earning capacity. The last arrangement of compensation is a December 1990 stipulation which increased claimant's permanent disability award to 47.5 percent. There is no evidence that claimant was under work restrictions at that time. The only evidence regarding claimant's earning capacity is a report from Dr. Ironside that, following an August 1989 exacerbation, he released claimant to part-time work for two weeks. (Ex. 108). We construe the report as indicating that, after two weeks, claimant was released to full-time work; claimant at that time worked as a manager for Izzy's pizza, a job that was very similar to his employment with Pizza Hut. In view of this evidence, we find that, at the time of the December 1990 stipulation, claimant was fully able to work as a manager at Pizza Hut.

Following his exacerbation, Dr. Ironside advised claimant to stop working. (Ex. 112). He also restricted claimant from working more than 40 hours per week and recommended that he avoid working in places having dust, toxic fumes or other irritants such as grease and oil. (Ex. 111). Similarly, Dr. Pappas recommended that claimant work in a job demanding "minimal physical exertion." (Ex. 138). Dr. Barnhart characterized claimant as having "relatively severe impairment with fairly limited employability." (Ex. 139). Like Dr. Ironside, both Dr. Barnhart and Dr. Pappas recommended that claimant's work environment be free of dust, fumes and irritants. (Exs. 138, 139).

We find that this evidence shows that, following the increase in symptoms, claimant no longer was able to work at Pizza Hut and that his physical capacities had diminished to the minimal level. Consequently, we conclude that claimant's increased symptoms resulted in a diminished earning capacity.

The December 1990 stipulation also provided that the award was "made in contemplation of future waxing and waning of claimant's symptoms." (Ex. 110-2). Therefore, claimant must also prove that the worsening is more than the waxing and waning contemplated by the stipulation. See Dana J. Fisher, 45 Van Natta 225 (1993).

We find that claimant carried his burden of proof with this element. Although claimant was exposed to Western Red Cedar in 1986 and has experienced exacerbations since that date, claimant's present physical capacities, as discussed above, have diminished to the most restricted level ever before exhibited. We find this to be strong evidence that the severity of claimant's condition exceeds the waxing and waning contemplated by the stipulation.

Therefore, we conclude that claimant proved a compensable aggravation.

Penalties and Attorney Fees

Claimant next asserts that SAIF's April 28, 1992 denial of the compensability of claimant's current condition was unreasonable.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). Whether a denial is unreasonable depends upon whether a carrier has a legitimate doubt regarding its liability, based on the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Continuation of that denial can also become unreasonable if, and only if, new evidence destroys any legitimate doubt about liability. Id. at 592; Georgia-Pacific Corp., v. Arms, 106 Or App 343, 347 (1991).

Claimant argues that the only opinion indicating that claimant's accepted asthma condition was not the cause of his current condition was that of Dr. Montanaro and that, because his opinion was based on the erroneous belief that claimant's condition was not permanent, it did not constitute legitimate doubt regarding liability.

At the time that SAIF issued its current condition denial, Dr. Montanaro had provided an opinion regarding the cause of claimant's current symptoms. In that report Dr. Montanaro diagnosed bronchial asthma, stating that the condition became symptomatic with multiple triggers. (Ex. 126-4). Dr. Montanaro also noted a "history of possible western red cedar asthma--resolved." (Id).

Dr. Montanaro continued to hold this opinion after the denial issued, supported somewhat by Dr. Pappas. (Exs. 130; 138). At the deposition, Dr. Montanaro did not change his opinion. (Ex. 141A-51-52). However, during the deposition this exchange took place between claimant's counsel and Dr. Montanaro:

> "Q. I'm also going to ask you to assume that not only did he have [western red cedar asthma], okay, but that he actually had a 45 percent permanent impairment from Western Red Cedar asthma. In the context of the Workers' Compensation case, it came to a 45 percent disability. I'm going to ask you to assume that. Okay?
>
> "A. Okay.
>
> "Q. If you assume those two things, is there any way to say now that Western Red Cedar asthma is no longer a major cause of his current problem.
>
> "A. No." (Ex. 141A-42)(emphasis supplied).

Because the "law of the case" is that claimant has an accepted western red cedar asthma condition for which he has received permanent disability, claimant contends that the above negative response by Dr Montanaro destroyed any legitimate doubt SAIF had regarding compensability of claimant's current condition. Claimant relies on Kuhn v. SAIF, 73 Or App 768 (1985).

As a legal matter, claimant has an accepted western red cedar asthma for which he has received permanent disability. However, that does not resolve the medical issue of whether or not the accepted condition is the major contributing cause of claimant's current condition. Based on Dr. Montanaro's opinion, we find SAIF had a legitimate doubt as to the compensability of claimant's current condition claim when it issued its denial. Moreover, subsequent to the denial, we do not find that "new evidence" destroyed this legitimate doubt. Finally, we do not interpret Dr. Montanaro's answer to the counsel's question to be an affirmative statement that claimant's accepted condition is the major contributing cause of claimant's current condition. Therefore, we do not find that "any legitimate doubt" of compensability was destroyed. Claimant is not entitled to penalties and attorney fees for an unreasonable denial.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against SAIF's denial of aggravation. 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 claimant's attorney's services at hearing and on review regarding the aggravation issue is $8,000, payable by SAIF. In reaching this conclusion,

we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services at hearing, the record, and claimant's appellant's and reply briefs), the complexity of the issue, the value of interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated April 23, 1993, as reconsidered May 4, 1994, is reversed in part and affirmed in part. The SAIF Corporation's denial of claimant's aggravation claim for an asthma condition is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee for services at hearing and on review regarding the aggravation issue of $8,000, to be paid by SAIF.

In the Matter of the Compensation of
CRAIG L. HIATT, Claimant
WCB Case No. 92-14383
ORDER ON REVIEW
Donald E. Beer, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Referee Peterson's order that: (1) set aside its denial of claimant's injury claim for left hearing loss condition; and (2) assessed a penalty for the employer's allegedly unreasonable delay in paying claimant's permanent disability award. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following additional finding. The claim was originally accepted as nondisabling, but was reclassified by the employer in January 1992 as disabling. We do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on February 26, 1990 when a piece of hot metal entered his left ear. Claimant's injury claim was accepted for nondisabling left otitis media. "Otitis media" is defined as "inflammation of the middle ear." Dorland's Illustrated Medical Dictionary (24th ed. 1965). The left otitis media claim was later reclassified as disabling and was closed by an April 13, 1992 Determination Order which awarded 6 percent (3.6 degrees) scheduled permanent disability for loss of hearing in the left ear. Claimant initially requested reconsideration of the Determination Order, but later withdrew his request. The Determination Order has become final.

New medical evidence subsequently revealed that claimant had a left-sided high frequency sensorineural hearing loss which preexisted the compensable "slag burn" injury and resulted from noise exposure as opposed to physical injury. (Exs. 15; 17). In response to this new medical evidence, the employer denied "left hearing loss" on November 2, 1992. (Ex. 27). Claimant requested a hearing concerning the denial.

The Referee found that the employer was barred by the doctrine of res judicata from denying claimant's left hearing loss since it did not appeal the April 13, 1992 Determination Order hearing loss award. The Referee further found that the employer unreasonably delayed paying the permanent disability award.

Res Judicata

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). There was no "actual litigation" of the Determination Order, therefore issue preclusion does not apply.

Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980).

We conclude that the high frequency sensorineural hearing loss is a new claim which is separate from the accepted otitis media claim. The "factual transaction" at issue in the April 1992 Determination Order was the closure and "rating" of the February 1990 compensable injury accepted for otitis media. All of the physicians who have addressed the source of claimant's high frequency left-sided hearing loss have concluded that it existed prior to the 1990 compensable injury. (Exs. 15; 29; 33-7). In other words, the hearing loss condition, as opposed to claimant's accepted otitis media condition, was not caused or worsened by the compensable injury. Thus, claimant's preexisting hearing loss and the issues arising from the 1990 compensable injury do not arise out of the same aggregate of operative facts. Because the already existing hearing loss and the February 1990 injury do not arise from the same factual transaction, they do not constitute the same "claim" for claim preclusion purposes. Therefore, claim preclusion does not apply.

Accordingly, since the left hearing loss and otitis media claims do not arise out of the same factual transaction (the February 1990 injury), the April 1992 Determination Order did not present a prior opportunity to litigate the compensability of claimant's left hearing loss. On this basis, we conclude that the employer is not barred by res judicata from denying claimant's left hearing loss.

In any event, although the Determination Order awarded permanent disability benefits for "hearing loss," and the employer paid them, this does not equate with acceptance of the left hearing loss condition or an admission of liability for that condition. See ORS 656.262(9) (Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability); see also Dotty C. Fowler, 45 Van Natta 951 (1993) (payment of a permanent disability award does not constitute an acceptance of the condition for which the compensation was paid).

In reaching our decision, we note that claimant has a high frequency sensorineural noise induced hearing loss on the left. However, the employer's denial purported to deny "left hearing loss" generally. The law of the case is that claimant has permanent disability in the form of left hearing loss as a result of the accepted otitis media condition. Thus, we construe the employer's denial to specifically deny left high frequency sensorineural hearing loss (noise induced), rather than the permanent disability related to the otitis media claim. Such a construction is consistent with the employer's arguments both at hearing and on review that the condition it had denied was a high frequency noise induced hearing loss on the left.

Having determined that res judicata does not bar the employer from denying claimant's left hearing loss condition, we turn to the merits of the denial.

Compensability

Four physicians address the causation of claimant's left hearing loss. All four physicians diagnosed high frequency hearing loss. Dr. Dowsett, claimant's attending physician, initially attributed the left hearing loss to claimant's 1990 compensable injury. However, at the time he rendered his initial opinions regarding the cause of the hearing loss, Dr. Dowsett had not seen claimant's pre-employment audiogram which was performed in April 1989, prior to claimant's February 1990 injury. Upon reviewing claimant's pre-employment audiograms, Dr. Dowsett concluded that they revealed a high frequency hearing loss. Dr. Dowsett further concluded that claimant's hearing level is currently the same as it was at the time of his pre-employment audiogram.

Dr. Hodgson, otolaryngologist, examined claimant at the employer's request. Dr. Hodgson found a high tone hearing loss in the left ear, but, based on the April 14, 1989 pre-employment audiogram, he concluded that the hearing loss was present prior to the February 26, 1990 injury. Dr. Hodgson also opined that claimant's high frequency sensorineural-type hearing loss in the left ear is typical of noise-induced exposure as opposed to hearing loss caused by physical damage to the eardrum or inner ear. Dr. Hodgson concluded that there was no permanent damage due to claimant's industrial injury.

Dr. Stevens, an otolaryngologist, issued a medical arbiter's report before claimant withdrew his request for reconsideration of the Determination Order. Dr. Stevens concluded that claimant's hearing loss existed prior to claimant's injury and is unrelated to the burn injury. Dr. Mettler also examined claimant. Taking into account the April 14, 1989 pre-employment audiogram, Dr. Mettler concluded that claimant had zero percent loss of hearing in the left ear.

All of the physicians who examined or treated claimant have either concluded that his high frequency hearing loss on the left was present prior to, and/or was unrelated to, the compensable injury. Accordingly, we conclude that claimant has not established compensability of his high frequency noise induced hearing loss of the left ear.

Penalties

The Referee assessed a penalty against the employer for an allegedly unreasonably late payment of permanent disability. On review, the employer asserts that it did not unreasonably delay payment of compensation. We agree.

The April 13, 1992 Determination Order awarded 6 percent scheduled permanent disability. The employer sent a check to claimant's last known address on April 24, 1992. Claimant did not receive the check and it was not returned to the employer. In October 1992, the employer became aware that the check had not been cashed. The employer's processing agent wrote to claimant on October 13, 1992 inquiring about the status of the check. The letter was subsequently returned as undeliverable. The agent then checked with the employer's accountant to determine whether the check had been cashed or returned. In late November, the processing agent decided to void the check and waited until confirmation that the check was void. This confirmation came in December and the employer then reissued an award check to claimant.

The Referee found that the employer's actions were reasonable up to the point that it stopped payment on the check after its letter to claimant was returned as undeliverable. However, the Referee found that the employer's subsequent actions were unreasonable warranting a penalty. We disagree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). OAR 436-60-150(1) provides, in part: "[b]enefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the US Mail."

Here, the employer promptly paid claimant's award in compliance with the rule. Subsequently, it discovered that the check had not been cashed and investigated. After stopping payment on the check, the employer reissued the check and mailed it to claimant's attorney. Given that the employer went beyond the requirements of OAR 436-60-150(1) to ensure that claimant received the award check, we do not find that it unreasonably delayed paying claimant's compensation. Furthermore, based on the claims representative's testimony, we conclude that the employer adequately explained the reasons for its delay in reissuing the check. Accordingly, we reverse the Referee's penalty assessment.

ORDER

The Referee's order dated February 25, 1993 is reversed. The denial is reinstated and upheld. The Referee's assessment of a penalty is reversed. The Referee's assessed attorney fee award is also reversed.

In the Matter of the Compensation of
CHARLES A. IRWIN, Claimant
WCB Case No. 93-01733
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Westerband and Haynes.

The self-insured employer requests review of those portions of Referee Peterson's order that: (1) set aside its denial of claimant's low back condition; and (2) awarded an assessed fee of $1,400 for an untimely acceptance of contusions to the neck, right shoulder, right elbow and chest. The employer also requests remand for the admission of a post-hearing medical report. On review, the issues are compensability, remand, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

On June 26, 1992, claimant fell off a ladder at work. Claimant initially was treated at the emergency room by Dr. Cowgill, who diagnosed a low back strain. (Ex. 1). A follow-up examination was conducted by Dr. Gavlick, who also diagnosed a low back strain, further noting that claimant exhibited "some evidence of symptom magnification." (Ex. 3). Dr. Lorish, physical medicine and rehabilitation specialist, became claimant's treating physician. Dr. Lorish agreed with the diagnosis of lumbar strain and prescribed physical therapy. (Ex. 7).

When claimant's pain continued unabated, Dr. Lorish ordered an MRI; it was interpreted as showing mild degenerative disc changes at L4-5 and L5-S1, including a "mild disc bulge" at L4-5, with mild foraminal stenoses at the same levels. (Ex. 9). Dr. Lorish found that the MRI was "entirely negative" and provided "nothing to explain his symptoms." (Ex. 10).

At the employer's request, claimant then underwent a physical examination by Drs. Wilson, neurologist, and Fry, orthopedic surgeon. They diagnosed lumbar strain and "probable conversion reaction." (Ex. 14-4). Their report also noted that claimant's "disability seems to be on an emotional basis rather than physical basis." (Id).

Upon referral by Dr. Lorish, claimant was examined by Dr. Thompson, surgeon. He diagnosed a lumbosacral strain and "marked functional overlay or psychophysiologic pain reaction," also stating that he was "strongly suspicious of secondary gain in this individual." (Ex. 17-3). Dr. Lorish also noted a "great deal of pain amplification" when he subsequently rechecked claimant. (Ex. 19).

Dr. Nash, neurosurgeon, then became claimant's treating physician. Dr. Nash found "signs and symptoms in the L5-S1, left-sided nerve root entrapment. This is based upon history, the altered deep tendon reflexes, compromise of motor power, dermatomal sensory loss, positive neuro stretch signs, and muscle atrophy[.]" (Ex. 22-3). A CT scan was interpreted as showing a "moderate bulge of the disc at the L4-5 region with some focal characteristics toward the right side" and "bilateral foraminal narrowing of a bony nature seen at the L5-S1 region." (Ex. 21). Based upon these results, Dr. Nash diagnosed "lumbar radiculopathy, L5-S1, due to an L4-5 focal disc prolapse and bilateral foraminal stenosis at L5-S1." (Ex. 22-3).

At Dr. Nash's request, Dr. Berkeley, neurosurgeon, examined claimant. Dr. Berkeley, based on the clinical examination, found "severe left radicular symptoms and signs compatible with an L4-5 prolapsed intervertebral disc and also possible left L5-S1 foraminal stenosis." (Ex. 24-3). He also found, however, that the MRI and CT scans were "equivocal." (Id).

In January 1993, Dr. Nash recorded right leg symptoms for the first time. (Ex. 32-1). Dr. Nash subsequently reported to claimant's attorney that, based on claimant's history and the diagnostic imaging studies, the major contributing cause of his low back condition and disc condition was the industrial accident. (Ex. 33-1). Dr. Nash explained that the disc condition was a "separate and new injury" and that the stenosis was "secondary to the disc changes." (Id).

A second MRI was again interpreted as showing mild degenerative disc changes at L4-5 and L5-S1, including a mild disc bulge at L4-5, with mild foraminal stenoses at the same levels; no changes from the prior study were noted. (Ex. 34).

Claimant underwent a second examination at the request of the employer by Dr. Wilson and Dr. Logan, orthopedic surgeon. The panel again diagnosed chronic lumbar strain and conversion reaction, finding "very strong evidence for a functional overlay." (Ex. 35-6). In particular, the physicians found that the sensory loss reported by claimant was not in a "dermatomal distribution;" the reflexes were symmetrical; and the "give-way weakness has the clear flavor of poor effort" and not of the type associated with radiculopathy. (Ex. 35-6).

The panel further opined that claimant had a "mild disc bulge, but not a prolapse" and that the condition was not causing any symptoms. The report also found that the bulge shown by the CT scan was not the cause of any symptoms because the focal characteristics were on the right side and claimant's symptoms were on the left side. (Id. at 7).

In a report to claimant's attorney, Dr. Berkeley stated that claimant had protruded discs at L4-5 and L5-S1. (Ex. 36-1). However, he disagreed with Dr. Nash that the disc condition was a new and separate condition that resulted from the accident. Instead, based on his understanding that claimant had no back symptoms prior to the accident, he opined that the disc bulge and degenerative changes preexisted the fall and that the accident was "superimposed" on the preexisting condition, causing claimant's symptoms. (Id. at 1-2). Therefore, Dr. Berkeley found that the accident was the major contributing cause of claimant's need for treatment. (Id).

Drs. Lorish and Thompson concurred with the report from Drs. Wilson and Logan. (Exs. 37, 38). Dr. Lorish emphasized that he had not actually viewed the CT and MRI studies but, based on reports of the studies, his opinion had not changed. (Ex. 41-2).

The employer accepted claims for lumbar strain and contusions to claimant's neck, right shoulder, right elbow and chest. It denied a claim for disc conditions at L4-5 and L5-S1 as well as radiculopathy and left hip and left leg conditions. The employer asserts, first, that claimant failed to prove that he has a disc condition and, second, the condition was caused by the industrial accident.

We disagree that claimant failed to prove the existence of a disc condition. Such a diagnosis is supported by Dr. Nash, Dr. Berkeley, and Drs. Wilson and Logan. The contrary opinions are provided by Drs. Lorish and Thompson, and the initial report from Dr. Wilson and Dr. Fry, all of which were rendered before the CT scan and second MRI study. Therefore, we find that the latter opinions, with regard to whether claimant has a disc condition, are not based on a complete history and, therefore, entitled to less weight. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, the existence of a disc condition at L4-5 and L5-S1 is supported by both MRI and CT studies. Consequently, we conclude that claimant proved the existence of a disc condition at L4-5 and L5-S1.

We are not persuaded, however, by Dr. Nash's opinion that claimant's disc condition was caused by the industrial accident. First, we find it significant that Dr. Gavlick, Dr. Lorish, who initially treated claimant, and Dr. Thompson, who saw claimant on referral, as well as those physicians who saw claimant on behalf of the employer, all found symptom amplification. Based on this evidence, we find that claimant's reports of his condition to the physicians are not credible and that the medical opinions are not reliable to the extent that they rely on such reports. Therefore, this case involves expert analysis of the diagnostic studies rather than expert observation of claimant's condition. Consequently, we give no particular deference to Dr. Nash as the treating physician. See Hammons v. Perini Corp., 43 Or App 299 (1979).

With regard to the MRI and CT studies, Dr. Nash explained that he interpreted the changes shown on the MRI as "regional changes produced in the lumbar vertebral spine by the disc herniation" rather than representing a condition that preexisted the fall. (Ex. 33-2).

We find that this rationale was effectively disputed by the panel of Drs. Wilson and Logan. In their report, the physicians stated that the degenerative changes shown in the first MRI would not have developed by the time the MRI was done if they had begun with the accident. The panel therefore found that the changes preexisted the fall. The panel further indicated that the condition shown by the CT scan could not be the cause of claimant's symptoms since it showed right-sided impingement and claimant's symptoms were on the left side. (Id). The panel's opinion that claimant's disc condition preexisted the accident is supported by Dr. Berkeley. Furthermore, Dr. Nash rendered his opinion before the second MRI was conducted, which again was interpreted as showing degenerative changes. For all these reasons, we find that Dr. Nash's opinion is overcome by the opinion of Drs. Wilson and Logan. See Somers v. SAIF, supra.

Finally, we are not persuaded by Dr. Berkeley's opinion that the June 1992 injury was superimposed on his preexisting condition. First, Dr. Berkeley's opinion relies on claimant's history that he had no symptoms before the accident. In view of our finding above that claimant is not credible, and because claimant is the source of the history, we find that it is not reliable. Furthermore, other than to state that there was "an element of nerve root entrapment syndrome," Dr. Berkeley in no way explains how the injury became superimposed on the condition or why the injury, rather than the preexisting condition, necessarily is the major contributing cause of the need for treatment.

In short, we find that the opinion of Drs. Wilson and Logan is the most well-reasoned and, consequently, the most persuasive. According to their report, the June 1992 injury did not contribute to claimant's disc condition at L4-5 and L5-S1. Consequently, we conclude that claimant failed to prove the compensability of his disc condition at L4-5 and L5-S1 and radiculopathy. See ORS 656.005(7)(a); 656.005(7)(a)(B).

Remand

The employer seeks remand for the admission of a chartnote by and emergency room physician for treatment rendered to claimant in August 1993. The document states that claimant had been seen in the emergency room "several times in the past," describing the last time as being for a motor vehicle accident during which claimant "had no evidence of injury--no abrasions, contusions or anything else. Also, when the police arrived [claimant] changed his story dramatically and seemed to improve without any treatment prior to discharge." The chartnote also states that claimant had been seen another time for a fall in the shower when again he had "no evidence of trauma and seemed to improve dramatically after being given IM narcotics." The physician diagnosed chronic neck and back pain and "possible drug seeking behavior."

The employer argues that the chartnote is relevant to whether claimant displayed functional overlay and, because it was the result of an examination that occurred after the hearing, was not available at the time of hearing.

Under ORS 656.295(5), 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. In order to satisfy this standard, a compelling reason must be shown for remanding. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Having found above that claimant is not credible with regard to his symptoms and condition, we conclude that remand would not change the outcome of the case and, therefore, there is no compelling reason to remand. Consequently, we deny the employer's motion.

Attorney Fees

Finally, the employer challenges the Referee's award of $1,400 for its late acceptance of contusion to claimant's neck, right shoulder, right elbow and chest. Although not disputing claimant's entitlement to a carrier-paid fee, the employer contends that the amount awarded by the Referee is excessive.

After considering the factors set forth in OAR 438-15-010(4), we conclude that the Referee's attorney fee award is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the issue (as reflected by claimant's counsel's affidavit and itemization of services), the complexity of the issue, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated June 1, 1993 is reversed in part and affirmed in part. That portion of the order finding that claimant's disc condition at L4-5 and L5-S1 compensable is reversed. The employer's denial of said condition is reinstated and upheld. The Referee's $1,622 attorney fee award for overturning the denial is reversed. The remainder of the order is affirmed.

February 3, 1994 Cite as 46 Van Natta 198 (1994)

In the Matter of the Compensation of
SKIP W. IVIE, Claimant
WCB Case No. 93-00068
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Referee Bethlahmy's order that required claimant's attorney to seek, directly from claimant, an "out-of-compensation fee" for previously paid temporary disability compensation. On review, the sole issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant, through his attorney, requested a hearing seeking additional temporary disability benefits. Shortly thereafter, the SAIF Corporation paid claimant the entire amount of the disputed time loss, without withholding or paying any amount as an approved attorney fee. SAIF made the payment without consulting with claimant's attorney. When SAIF took this action, it had in its possession a copy of claimant's hearing request and an executed retainer agreement between claimant and his attorney. The retainer agreement provided for an approved attorney fee in the amount of 25 percent of any additional temporary disability compensation obtained for claimant.

CONCLUSIONS OF LAW AND OPINION

The Referee authorized an approved fee in the amount of 25 percent of the additional time loss paid by SAIF. However, the Referee concluded that claimant's attorney must recover the fee from claimant, rather than from SAIF. The Referee reasoned that she did not have the authority to order SAIF to pay the fee because the entire temporary disability award had been paid out. On review, claimant asks the Board to order SAIF to pay the fee. In the alternative, claimant's attorney requests that the Board modify the Referee's order language to clarify that the fee can be recovered directly from claimant.

After the Referee issued her order in this case, the Board addressed a similar situation in Nancy E. O'Neal, 45 Van Natta 1591 (1993) (second order on remand), 45 Van Natta 2081 (1993) (third order on remand). In O'Neal, the claimant filed a supplemental hearing request raising an issue regarding the rate of temporary disability compensation. Prior to the hearing, the SAIF Corporation recalculated the claimant's award and paid the claimant the disputed amount. It did so without contacting the claimant's attorney or paying the attorney a fee out of the increased compensation. A Referee subsequently approved a fee in the amount of 25 percent of the increased compensation. The Board concluded that, in this particular situation, it was not inequitable to require SAIF to pay the fee. The Board relied on the fact that the claimant's attorney could not have taken any other action to secure receipt of the fee, and SAIF knew that the claimant was represented by counsel when it paid out the entire award. On this basis, the Board distinguished its decision in O'Neal from prior orders in which it required the claimant's attorney to seek an out-of-compensation fee for previously paid compensation directly from the claimant. See Gabriel M. Gonzales, 44 Van Natta 2399 (1992); Kenneth V. Hambrick, 43 Van Natta 1636 (1991); Gerald L. Billings, 43 Van Natta 399 (1991); Mohammad Zarifi, 42 Van Natta 670 (1990).

The O'Neal decision is controlling in the present case. As in O'Neal, claimant's attorney in this case took all possible actions to secure his fee, and SAIF knew that claimant had retained counsel when it paid out the entire award. Accordingly, we conclude that it is not inequitable to require SAIF to pay the disputed fee to claimant.

In reaching this decision, we note SAIF's argument that, at the time it paid the award, it had no authority to pay an out-of-compensation fee that had not been approved by a Referee. SAIF further argues that if it had not paid the entire award to claimant it would have been at risk of a penalty. We previously considered and rejected SAIF's argument in our decision in O'Neal, supra. In particular, we explained that our decision was not premised on whether the fee had been approved by a Referee so that there was an enforceable lien. We instead relied on the fact that claimant took all possible actions to secure the fee, and SAIF was aware claimant was represented when it paid out the award. We further explained that SAIF could have avoided a penalty by consulting with claimant's attorney and arriving at a stipulated agreement prior to paying out the disputed award. We continue to adhere to this reasoning.

Accordingly, we conclude that SAIF is required to pay claimant's attorney the out-of-compensation fee. SAIF is authorized to recover the overpayment created by this order from future permanent disability awards under this claim.

ORDER

The Referee's order dated April 23, 1993 is reversed. The SAIF Corporation is instructed to pay claimant's attorney an out-of-compensation fee in the amount of $519.44. SAIF is authorized to offset this amount against future payments of permanent disability compensation.

February 3, 1994 Cite as 46 Van Natta 199 (1994)

In the Matter of the Compensation of
BEVERLY A. PATTERSON, Claimant
WCB Case No. 92-07033
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of those portions of Referee Davis' order that: (1) upheld the self-insured employer's partial denial of her current left chest, shoulder, hair loss and stress conditions; and (2) declined to award claimant temporary disability benefits after January 15, 1992. In its brief, the employer disagrees with that portion of the Referee's order that awarded claimant's counsel an assessed attorney fee for obtaining rescission of the employer's denial of claimant's medical services bills. On review, the issues are compensability, temporary disability benefits and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant relies upon the opinion of her treating chiropractor, Dr. Flowers. Although Dr. Flowers opined that claimant's other neck and back problems could have been involved at the time of the injury, he did not state that treatment of those areas was necessary in order to treat claimant's thoracic condition. Furthermore, Dr. McKillop of the Orthopaedic Consultants reported that claimant had numerous subjective symptoms and, due to voluntary guarding during examination, he was unable to state that claimant had objective findings.

Dr. Parvaresh, psychiatrist, examined claimant for the employer and diagnosed a somatoform disorder, which was probably "the expression of the underlying psychological problem that has taken on the form of vague and ill-defined physical symptomatology." Dr. Parvaresh concluded that claimant's psychological problem was unrelated to the compensable injury, and he opined that further palliative treatment would confirm claimant's belief that something was seriously wrong with her and claimant would "pursue treatment endlessly without adequately addressing the underlying problems."

Finally, Dr. Brett, D.O., saw claimant on referral from Dr. Goldberg, claimant's treating physician. Dr. Brett found full thoracic range of movement without discomfort and no tenderness over the spine or chest wall. In light of claimant's persistent symptoms, Dr. Brett recommended an MRI in order to rule out a cervical or thoracic disc herniation. Claimant's August 1991 MRI's of the cervical and thoracic spine were both normal.

After reviewing the medical record, we agree with the Referee's conclusion that claimant's current conditions are not compensable. Furthermore, we find no persuasive medical evidence to establish that treatment of claimant's current conditions is necessary in order to treat the compensable thoracic condition.

Temporary Disability Benefits

We adopt the Referee's Conclusions of Law and Opinion on the issue of temporary disability benefits.

Attorney Fees

The Referee concluded that the employer denied compensability of claimant's medical services. Because the employer withdrew its denials at the time of hearing, the Referee found that claimant's counsel was entitled to an attorney fee. See ORS 656.386(1).

On review, the employer contends that the Referee did not have jurisdiction over the issue of medical services. The employer argues that, prior to hearing, it had sought review from the Director. The employer contends that, rather than being denials of medical services, the letters it sent were merely "informative correspondence." We disagree.

The employer wrote to claimant's treating chiropractor, Dr. Flowers, and advised claimant that its denial covered "all medical treatment and disability to date." The employer also wrote to Portland Rehabilitation and Sports Medicine and stated that its treatment had been rendered for conditions that were not accepted.

Under the circumstances, we conclude that the employer was disputing compensability of claimant's medical services, as the employer denied that a causal relationship existed between claimant's medical services and her compensable condition. See Michael A. Jaquay, 44 Van Natta 173 (1992).[1]

Although the employer argues that it had requested review of the disputed medical services bills prior to the hearing before the Referee, claimant had filed her hearing request prior to the filing of the employer's "wish" for Director review. Furthermore, inasmuch as claimant's hearing request from the disputed medical bills was not premature (as the hearing request was filed more than 90 days from the date the employer had notice or knowledge of the claim) and preceded the employer's request for Director review, we are inclined to find that jurisdiction properly rested with the Hearings Division. In any event, the employer subsequently withdrew its substantive objection to claimant's medical bills. We interpret such withdrawal as a retraction of the employer's "wish" for Director review. Consequently, we conclude that the Referee had jurisdiction over the previously disputed medical bills issue, and we affirm his award of an assessed attorney fee.

Although claimant has prevailed over the insurer's request for review on the issue of attorney fees, no fee is available for Board services on review concerning that issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 15, 1993 is affirmed.

February 3, 1994 Cite as 46 Van Natta 201 (1994)

In the Matter of the Compensation of
DENNIS E. RINGLER, Claimant
Own Motion No. 94-0021M
OWN MOTION ORDER
Skalak & Alvey, Claimant Attorneys

The insurer has submitted an own motion recommendation in which it recommends that claimant's claim be reopened pursuant to the Board's own motion jurisdiction. The insurer notes that it voluntarily reopened claimant's claim and has closed that claim pursuant to a Notice of Closure under OAR 438-12-005. Thus, the insurer has treated this claim as an own motion claim. By letter dated January 21, 1994, claimant's attorney asserts that this claim is not within the Board's own motion jurisdiction. We agree with claimant's attorney's assertion.

The time lines within which to file aggravation claims are found at ORS 656.273(4):

> "(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."

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).

The insurer argues that there was no indication that claimant missed any time from work as the result of the injury in 1983 and, as a result, the claim was classified as nondisabling. The insurer further argues that the classification was changed to disabling when a request for surgery was made in 1992. Thus, the insurer argues, claimant's aggravation rights run from the date of injury and his claim is within the Board's own motion jurisdiction.

The record does not support the insurer's arguments. Contrary to the insurer's argument, there is no indication that this claim was processed or classified as nondisabling prior to the insurer's acceptance of the claim as disabling on July 15, 1992. Here, although claimant was apparently injured in 1983, his claim was not filed or processed until February 1992.

In addition, the record does not support the insurer's argument that there was no indication that claimant missed time from work in 1983 due to the injury. On the 801 form signed by claimant on February 7, 1992, the employer stated that claimant lost time from work from September 27, 1983 to October 10, 1983. This time loss indicates that the claim was disabling in 1983. Furthermore, on July 15, 1992, the insurer accepted the claim as disabling. As noted above, this is the first indication of any processing or acceptance of the claim. The conditions accepted were claimant's herniated discs at L4 and L5, the conditions for which claimant underwent surgery in October 1992. This claim has never been closed pursuant to ORS 656.268.

Under these circumstances, claimant's five year aggravation rights run from the date of the first closure of the claim pursuant to ORS 656.268, an event that has not yet occurred. ORS 656.273(4)(a); see Ronald J. Lakey, 45 Van Natta 122 (1993); David E. Kennedy, on recon, 44 Van Natta 1455 (1992). Therefore, because claimant's aggravation rights have not expired, claimant's claim is not within the Board's own motion jurisdiction. In addition, it follows that any claim closure must be made pursuant to ORS 656.268, not OAR 438-12-025, which is the Board's rule regarding closure of own motion claims.

Accordingly, we lack own motion jurisdiction to consider any request for claim reopening. Instead, the insurer should process this claim to closure pursuant to ORS 656.268.

IT IS SO ORDERED.

February 3, 1994 Cite as 46 Van Natta 202 (1994)

In the Matter of the Compensation of
PHON VEOPRADITH, Claimant
WCB Case No. 91-05537
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Miller, Nash, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Epson Portland, Inc. v. Veopradith, 122 Or App 293 (1992). The court reversed our prior order, Phon Veopradith, 44 Van Natta 2110 (1992), which set aside the self-insured employer's denial of claimant's back injury claim, but upheld its denial of claimant's current "resultant" condition. Citing Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's work activities on January 17, 1991 were a material contributing cause of his need for medical treatment until April 22, 1991, the Referee concluded that claimant had sustained a compensable low back injury. In reaching this conclusion, the Referee acknowledged that there had been no worsening of claimant's preexisting degenerative condition, which the Referee determined was the major contributing cause of claimant's low back condition. Nevertheless, reasoning that ORS 656.005(7)(a)(B) did not apply to the initial determination of compensability, the Referee set aside the employer's denial.

In our prior order, we agreed with the Referee's finding that claimant's January 17, 1991 work activities were a material contributing cause of his low back injury and, thus, the injury claim was compensable. Phon Veopradith, supra. However, we further found that claimant's preexisting degenerative condition was the major contributing cause of claimant's entire need for treatment during 1991. Inasmuch as claimant's work injury was not the major contributing cause of his "resultant" condition, we modified the Referee's order to the extent that he found claimant's need for treatment from January 1991 through April 22, 1991 to be compensable. We, instead, held that the employer was not responsible for that treatment. We relied on the reasoning expressed in Bahman N. Nazari, 43 Van Natta 2368 (1991).

Subsequent to our order, the court reversed our decision in Nazari. Interpreting ORS 656.005(7)(a)(B), the court reasoned as follows:

> "If, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an initial claim, the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment." Tektronix, Inc. v. Nazari, on recon at 594.

Citing Nazari, supra, the court has reversed our prior order and remanded for reconsideration.

The record consists of three medical opinions on the causation issue. Dr. Reimer, an examining physician, opined that claimant's low back strain combined with his preexisting degenerative condition, but that the preexisting condition was the major contributing cause of claimant's need for treatment. (Ex. 44-11, 14). Dr. Azhar, claimant's treating physician, agreed that the degenerative condition was the major contributing cause of claimant's need for treatment. (Ex. 45-1). Finally, Dr. Berkeley, neurological surgeon, also opined that the preexisting degenerative condition was the major contributing cause of claimant's need for treatment. (Ex. 44-2).

In light of these opinions, we are unable to conclude that claimant's disability or need for medical treatment was due to the January 17, 1991 injury alone. Rather, the record establishes that claimant's disability and need for treatment for his low back condition resulted from a combination of the work injury and a preexisting condition.

Thus, in order to establish compensability of his claim, claimant bears the burden of proving that the work injury was the major contributing cause of his resultant condition. See Nazari, supra. Based on the uncontradicted medical evidence, we conclude that claimant's preexisting degenerative condition is the major contributing cause of claimant's present low back condition and need for treatment. Therefore, claimant has not satisfied the statutory prerequisite. See ORS 656.005(7)(a)(B); Tektronix v. Nazari, supra. Consequently, the employer's denial must be upheld in its entirety.

Accordingly, on reconsideration, we reverse the Referee's order dated October 28, 1991. The self-insured employer's denial is reinstated and upheld.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBIN GORDON, Claimant
WCB Case No. 92-12169
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Schultz's order that upheld the SAIF Corporation's denial of his injury claim for low back condition and bilateral wrist pain. On review, the issue is compensability.

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

The record indicates that claimant suffered an "out-of-state" work-related low back injury in 1979. Claimant has had ongoing symptoms and sought emergency treatment for the 1979 low back injury less than a month before the August 17, 1992 work activities that gave rise to this claim. Claimant also had preexisting noncompensable bilateral carpal tunnel syndrome.

We agree with the Referee that claimant's 1979 "out-of-state" low back injury represents a "preexisting condition" under ORS 656.005(7)(a)(B). See Arlene M. Lawton, 46 Van Natta 98 (1994). ("Out-of-state" injury and subsequent condition represented a "preexisting condition" under ORS 656.005(7)(a)(B), requiring the claimant to prove that "Oregon" injury is and remains the major contributing cause of resultant disability or need for treatment).[1]

We likewise agree with the Referee that claimant has not established that his work activity on August 17, 1992 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), on recon 120 Or App 590 (1993). For the reasons stated by the Referee, we find the opinions of Drs. Hooshmand and Morris to be more persuasive than that of Dr. Reynolds. We note that Dr. Hooshmand treated claimant for the 1979 "out-of-state" injury on July 23, 1992, less than a month before the August 17, 1992 incident. Dr. Hooshmand reviewed the medical records from the August 17, 1992 incident and concluded that claimant had a flare-up of the same symptoms he had as a result of the 1979 injury and that there was nothing new added to the clinical picture. Dr. Morris, who had also treated claimant for low back symptoms prior to August 1992, agreed with Dr. Hooshmand that claimant's preexisting condition and his condition after the August 17, 1992 incident were identical. Accordingly, we agree with the Referee that claimant has not established compensability of his low back condition.

Given claimant's previous history of bilateral carpal tunnel syndrome and surgery to correct that condition, the compensability of claimant's bilateral wrist pain presents a complex medical question. Therefore, expert medical evidence is necessary to establish compensability of the bilateral wrist pain. Uris v. Compensation Department, 247 Or 420 (1967).

The only physician who relates claimant's "bilateral wrist pain" to claimant's work activities on August 17, 1992 is Dr. Reynolds. We are unpersuaded by Dr. Reynolds' opinion concerning claimant's bilateral wrist pain because it is conclusory and lacking in medical analysis and explanation. See Moe v. Ceiling Systems, 44 Or App 429 (1980). In addition, Dr. Hooshmand has indicated that claimant had carpal tunnel syndrome surgery in 1984 with good results, but that claimant continues to have numbness over the hands due to the preexisting old injuries to the cervical spine. Under the circumstances and given claimant's preexisting carpal tunnel syndrome and his prior 1979 injury which causes hand symptoms, we conclude that claimant has not established the compensability of his bilateral wrist pain.

ORDER

The Referee's order dated May 28, 1993 is affirmed.

[1] Member Gunn disagrees with the majority's holding in Lawton, supra. However, based on the doctrine of stare decisis, he is compelled to follow that holding.

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case Nos. 92-11012 & 92-10411
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Galton's order that declined to award penalties and attorney fees for the SAIF Corporation's allegedly unreasonable claims processing. On review, the issue is penalties and attorney fee. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the second sentence of the "Ultimate Findings of Fact" section.

FINDINGS OF ULTIMATE FACT

SAIF's failure to respond to claimant's claim for an adhesive capsulitis condition within 90 days of receiving notice of the claim constituted a de facto denial of that condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant did not seek formal acceptance of her adhesive capsulitis condition until less than 90 days before hearing. Therefore, the Referee found that SAIF's acceptance at hearing of claimant's adhesive capsulitis condition was both timely and reasonable. We disagree.

Notice or knowledge of a claim may be acquired directly from claimant or through another source. ORS 656.005(6). 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). A physician's report requesting medical treatment for a specified condition constitutes a claim. See ORS 656.005(6) and (8); Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992).

On January 21, 1991, Dr. Barnhouse, Kaiser Permanente physician, saw claimant and diagnosed: "Adhesive capsulitis of the left shoulder." Dr. Barnhouse noted that the examination was a "follow-up visit" concerning claimant's shoulder condition since the July 1990 work injury. Dr. Barnhouse treated claimant with a cortisone injection and prescribed home exercises for her shoulder.

On May 13, 1991, Drs. Wilson and Coletti, independent medical examiners (IME), diagnosed claimant's condition as: "Adhesive capsulitis of the left shoulder." Drs. Wilson and Coletti found that claimant's "impairment is due to the work-related injury." Drs. Wilson and Coletti opined that claimant did not require treatment for the condition.

On May 19, 1991, Dr. Jura, treating physician, reviewed the IME report and concurred with their diagnosis but disagreed with their conclusion that claimant did not require medical treatment. On June 3, 1991, Dr. Jura examined claimant concerning her shoulder condition in relation to the July 1990 injury. Dr. Jura prescribed "acute [physical] therapy" to rehabilitate and reduce the pain in claimant's shoulder.

We conclude that Dr. Jura's May 19, 1991 report constituted a claim. See Safeway Stores, Inc. v. Smith, supra. Therefore, SAIF was required to accept or deny claimant's claim within 90 days of the claim, or by August 17, 1991. SAIF failed to do so.

Entitlement to Penalty

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).

Entitlement to Attorney Fee

In SAIF v. Condon, 119 Or App 194 (1993), the court found that where there was no compensation due at the time of hearing, the insurer could not have unreasonably resisted the payment of compensation that had been paid. Accordingly, the court held that an award of attorney fees pursuant to ORS 656.382(1) was inappropriate as a matter of law. Here, in accordance with the rationale expressed in Condon, supra, we conclude that, because there was no compensation due at the time of hearing, no attorney fee is available under ORS 656.382(1).

However, we find that SAIF's acceptance at hearing constituted a rescission of its de facto denial. Although SAIF paid claimant's medical services for her adhesive capsulitis treatment, and contended that it had always treated the adhesive capsulitis component as part of the accepted claim, the mere payment of such bills does not constitute acceptance of a claim or an admission of liability. ORS 656.262(9); Euzella Smith, 44 Van Natta 778 (1992). However, SAIF's at-hearing acceptance of the adhesive capsulitis condition entitled claimant to compensation beyond the payment of medical bills. ORS 656.005(8); Euzella Smith, supra.[1]

Further, in light of the fact that SAIF accepted claimant's adhesive capsulitis condition claim at the hearing, we conclude that claimant's counsel was instrumental in obtaining SAIF's rescission and compensation for claimant's injury claim without a hearing. Therefore, claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services concerning rescission of SAIF's de facto denial is $150. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 3, 1993 is reversed in part and affirmed in part. Claimant is awarded an assessed fee of $150 under ORS 656.386(1) for counsel's services concerning SAIF's rescission of its de facto denial, to be paid by SAIF. The remainder of the order is affirmed.

[1] We note that, in SAIF v. Allen, 124 Or App 183 (1993), the court held that an attorney fee was not available under 656.386(1) where the issue involved a dispute over unpaid medical bills but the insurer was not a contesting a causal relationship. In Allen, the unpaid medical bills were attributable to an accepted condition. Here, although SAIF argues that it has always treated claimant's capsulitis condition as part of the accepted claim, SAIF initially accepted only a left shoulder strain. As explained above, claimant made a claim for her capsulitis condition, and that condition was not accepted until SAIF's rescission at hearing. Accordingly, because the capsulitis condition was not accepted, causation remained an issue until SAIF's rescission. Therefore, in contrast to Allen, claimant is entitled to an attorney fee award under ORS 656.386(1).

February 4, 1994 Cite as 46 Van Natta 206 (1994)

In the Matter of the Compensation of
FRANCES C. JOHNSON, Claimant
WCB Case No. 92-15069
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Referee Hoguet's order that: (1) increased claimant's unscheduled permanent disability award from 27 percent (86.4 degrees), as granted by an Order on Reconsideration, to 37 percent (118.4 degrees); (2) affirmed that portion of the Order on Reconsideration that awarded 14 percent (26.88 degrees) scheduled permanent disability for loss of use or function of the left arm; and (3) assessed a 25 percent penalty under ORS 656.268(4)(g). Claimant cross-requests review of the Referee's order, contending that her unscheduled award of permanent disability should be increased to 69 percent.

On review, the issues are extent of unscheduled permanent disability and penalties under ORS 656.268(4)(g). We modify the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his ultimate finding that claimant is entitled to 10 percent permanent disability for her compensable psychological condition.

CONCLUSION OF LAW AND OPINION

Employed as a registered nurse, claimant sustained a compensable left shoulder/cervical strain while caring for a patient. Dr. Denekas, neurologist, has been her attending physician throughout most of the claim.

In August 1989, claimant began treating with a psychologist, Dr. Stanulis, for a somatoform pain disorder and conversion reaction. On January 5, 1990, the employer denied the compensability of "any emotional or psychiatric condition." In July 1990, an earlier referee set aside the denial on the grounds that claimant's original injury was a material contributing cause of her need for psychological treatment.

Claimant last saw Dr. Stanulis in August 1991. The claim was closed by Notice of Closure on June 19, 1992, with an award of 5 percent scheduled disability for loss of use or function of her left arm. Claimant subsequently requested reconsideration.

The Appellate Unit appointed a medical arbiter panel consisting of an orthopedic surgeon and two psychiatrists. The psychiatrists rated claimant's psychological impairment pursuant to OAR 436-35-400(5)(b)(D)and (F) as class 2 (mild) or 23 percent; whereas Dr. Stanulis, with Dr. Denekas' concurrence, had previously rated her psychological impairment as class 3 or 50 percent. The medical-arbiter psychiatrists also opined that claimant's original injury was not the major contributing cause of her psychological disorder.

The November 18, 1992 Order on Reconsideration increased claimant's scheduled award to 14 percent and awarded her a total of 27 percent unscheduled permanent disability. These awards were based entirely on physical impairment in the left arm, left shoulder and cervical regions, according to the evaluator's worksheet. Claimant was not awarded permanent disability for psychological impairment because her original injury was not the major contributing cause of her psychological condition, according to the psychiatric medical arbiters.

Referee Hoguet held that the earlier referee's order found claimant's psychological condition compensable as a consequential condition and not on the basis of a preexisting condition or disease. Therefore, the Referee concluded that the major contributing cause requirement of ORS 656.005(7)(a)(B) did not preclude rating of claimant's psychological condition. Despite finding the rating of claimant's psychological impairment by the medical arbiter panel to be the most persuasive, the Referee did not award claimant the full amount of permanent disability supported by the arbiter's report. The Referee instead awarded claimant 10 percent unscheduled permanent disability for her psychological disability. The Referee determined that claimant's psychological condition only manifested itself in limiting use of her left arm and that she had already been compensated for her physical limitations by the prior awards of scheduled and unscheduled permanent disability.

Impairment Due to Injury

The employer initially contends that claimant has no psychiatric impairment due to the compensable injury because the original injury is no longer the major contributing cause of claimant's psychological condition, according to the psychiatric medical arbiters. The employer further asserts that the earlier referee did not find claimant's psychological condition compensable on the basis of a consequential condition. Rather, the employer argues that the earlier referee found claimant's compensable injury was a material contributing cause of her psychological condition, notwithstanding the presence of a preexisting psychological condition. Because claimant had a prexisting psychological condition, and because the earlier referee did not find that claimant's conversion disorder was a consequential condition, the employer argues that ORS 656.005(7)(a)(B) requires that her original compensable injury remain the major contributing cause of her psychological disability.

The initial issue is whether ORS 656.005(7)(a)(B) is applicable. The Referee interpreted the earlier referee's order as evaluating claimant's psychological disorder as a consequential condition of her May 1989 injury, with an analysis comparable to what is now ORS 656.005(7)(a)(A). The Referee further reasoned that only ORS 656.005(7)(a)(B) contains the requirement that the original injury remain the major contributing cause of disability or the need for medical treatment. Therefore, according to the

Referee, claimant need not prove that her original injury remains the major contributing cause of her psychiatric disability since subsection (B) of ORS 656.005(7)(a) was not applicable. The Referee apparently found that claimant's original injury was at least a material contributing cause of her current psychological condition.

The employer argues that the Referee misinterpreted the earlier referee's order, citing several references in the prior order to claimant's preexisting "psychological makeup" and "personality structure." Given those references, the employer contends that the earlier referee must have determined claimant's psychological condition to be compensable despite the presence of a "preexisting condition."

However, the medical records pertaining to claimant's psychological condition do not establish a preexisting psychological condition under ORS 656.005(7)(a)(B). For that statute to apply, there must have been a combination of a compensable injury and a preexisting psychological condition that caused a need for disability or treatment. We agree with claimant that the medical record merely shows that she was predisposed to developing a conversion disorder. Such a predisposition does not necessarily constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B). See Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991)

Moreover, the court recently held in Beck v. James River Corp., 124 Or App 484, 488 (1993), that ORS 656.005(7)(a) only applies to claims for new injuries or conditions different from an already accepted claim. There is no medical evidence that claimant's current psychological condition is different from her already accepted psychological claim. Therefore, under Beck, ORS 656.005(7)(a)(B) is inapplicable to this claim.

Assuming arguendo that ORS 656.005(7)(a)(B) did apply, thereby requiring a major contributing cause analysis, we would still find that claimant's injury remains the major contributing cause of her psychological disability[1]. Although the psychiatric arbiters stated that they did not view claimant's work injury as the major contributing cause of claimant's conversion disorder, this conclusion was unexplained. (Ex. 99-8). It is well-settled that conclusory opinions are entitled to little weight. See Michael Holt, 45 Van Natta 849, 850 (1993).

Claimant's treating psychologist, Dr. Stanulis, opined that as of his last treatment in August 1991, claimant's psychological symptoms were related to her compensable injury. Granted Dr. Stanulis' opinion referred to the earlier referee's order and commented that claimant's disability "would have to be related in that context." (Ex. 85). However, claimant was asymptomatic from a psychological standpoint prior to her compensable injury, despite her predisposition to develop a conversion reaction. It was only after her injury that she developed her psychological disorder and required medical treatment. In light of this, and the conclusory nature of the arbiter's opinion on medical causation, we interpret Dr. Stanulis' opinion as supporting a conclusion that claimant's original compensable injury remains the major contributing cause of claimant's psychological disability. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) (where a degenerative disc disease was asymptomatic prior to a compensable injury and remained so thereafter, claimant's cervical strain was still the major contributing cause of disability and need for treatment); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) (use of "magic words" unnecessary to establish medical causation).

Separate Scheduled and Unscheduled Awards

The employer next contends that the Referee erred in awarding unscheduled permanent psychological disability because claimant's scheduled permanent disability award had already compensated her for her impairment resulting from her psychological condition. The employer argues that claimant's psychological impairment manifested itself in a scheduled body part by limiting use of her arm; therefore, to award claimant unscheduled permanent disability would overcompensate her for her permanent disability when she had already been compensated for the effects of her conversion disorder. Claimant responds by asserting that her unscheduled psychological impairment is separately compensable from her scheduled physical impairment.

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[1] We note parenthetically that the court in Cox v. SAIF, 121 Or App 568 (1993), held that a consequential condition previously determined compensable under pre-1990 law cannot be relitigated under the stricter compensability standards of ORS 656.005(7)(a)(A). Thus, if claimant's psychological condition was analyzed as a consequential condition, the employer would be precluded from contesting the compensability of the condition.

Both the employer and claimant cite Foster v. SAIF, 259 Or 86 (1971) as supporting their positions. In Foster, the claimant sustained a shoulder injury with referred pain into the arm. The claimant received an unscheduled award of permanent disability for the shoulder as well as a scheduled award for the arm. In this case, claimant has sustained an injury to the mind as well as to left side of her body. Claimant's additional physical impairment was referred from the injury to her psyche, i.e., the conversion disorder, since the only apparent consequences of the psychological injury are limitations on use of her left arm.

Foster holds that a claimant can receive separate scheduled and unscheduled awards in cases such as this where an unscheduled injury results in referred disability in a scheduled body part. In addition, the standards for rating permanent disability provide for assessment of disability caused by both physical and psychological injuries. They do not authorize an offset of one award against the other in this context. See OAR 436-35-400. The applicable standards for rating mental illness specifically provide for impairment due to conversion reactions. Id. Furthermore, the court has held that conversion reaction disorders and their consequences can be compensable. See Kobayashi v. Siuslaw Care Center, 76 Or App 320, 324 (1985) (clubfoot sustained as a result of a compensable conversion reaction disorder held compensable).

For these reasons, we agree with the Referee that claimant was entitled to a separate unscheduled permanent disability award for her psychological impairment. However, we disagree with the Referee's award of 10 percent unscheduled permanent disability for claimant's psychological condition.

Like the Referee, we, too, find that the medical arbiter's report is the most persuasive medical evidence addressing claimant's psychological impairment. The medical arbiter psychiatrists provided the most recent assessment of claimant's psychological condition. Because there is no basis for awarding less than the 23 percent unscheduled permanent disability supported by the arbiter's report, we find that claimant is entitled to 23 percent unscheduled permanent disability for her psychological impairment. We accordingly modify the Referee's order to reflect this award.

Finally, the employer contends that the Referee incorrectly assessed a penalty under ORS 656.268(4)(g). We affirm the Referee's award. Kevin Northcut, 45 Van Natta 173 (1993).

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 claimant's response to the employer's request for review pertaining to the unscheduled and scheduled permanent disability issues 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. Claimant's attorney is not entitled to an assessed fee under ORS 656.382(2) for defending the Referee's penalty assessment. 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 3, 1993 is modified. In addition to the Referee's and the Order on Reconsideration awards of 37 percent (118.4 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) for a total award to date of 47 percent (150.4 degrees) unscheduled permanent disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order. However, the total "out-of-compensation" attorney fee granted by the Referee's order and this order shall not to exceed $3,800. The remainder of the Referee's order is affirmed. For services on review regarding the employer's appeal of the permanent disability issues, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the employer.

In the Matter of the Compensation of
TIMOTHY O. REYNOLDS, Claimant
WCB Case No. 91-01831
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Brown's order that set aside its denial of claimant's right wrist condition. In its brief, the employer also asserts that the Board improperly remanded the case to the Referee for further evidence taking. On review, the issues are remand and compensability. We affirm.

FINDINGS OF FACT

We republish the "Findings of Fact" set forth in the Order on Review (Remanding) (Timothy O. Reynolds, 42 Van Natta 2227 (1992)) and provide the following supplementation.

In the first hearing in this proceeding, the Referee upheld the employer's denial of a claim for mid-carpal instability or scapholunate dissociation. The Referee reached this conclusion by relying on the opinion of Dr. Nathan, hand surgeon, who had found that claimant's symptoms were caused by a ganglion.

Following the hearing but before Board review, claimant was examined by Dr. Woolpert, orthopedic surgeon, at the request of the employer. During this time, claimant also underwent a ganglionectomy, whereby Dr. Nathan excised a ganglion from claimant's right wrist. Despite the procedure, claimant continued to experience symptoms.

On Board review, claimant requested remand in order to admit evidence concerning the surgery and its aftermath. The Board allowed the motion and remanded the case to the Referee for further proceedings. On remand, the Referee admitted additional evidence and entered an order finding claimant's right wrist condition compensable.

CONCLUSIONS OF LAW AND OPINION

Remand

The employer first asserts that the Board improperly granted the motion to remand, specifically contending that the post-hearing evidence was not reasonably likely to affect the outcome of the case. The Board's prior order sufficiently explains the rationale supporting remand. Timothy O. Reynolds, supra. Therefore, we find it unnecessary to further respond to the employer's argument.

Compensability

In April 1989, claimant sustained an injury to his right wrist. The employer accepted a claim for recurrent right wrist capsulitis with recurrent extensor tendinitis. On referral from claimant's treating orthopedic surgeon, Dr. Appleby, claimant was examined by Dr. Buehler, hand surgeon. Dr. Buehler diagnosed scapholunate dissociation and recommended arthroscopic surgery.

Dr. Nathan diagnosed a ganglion that could have been caused by the work injury, carpal tunnel syndrome, and congenital bilateral hypermobile wrists. (Ex. 51-6). Dr. Nathan further found that other diagnoses were not confirmed by his examination or the radiologic findings. (Id.)

Dr. Buehler continued to adhere to his diagnosis of scapholunate dissociation, stating that claimant's examination was "classic" for this problem and that such a condition was not seen on x-ray or arthrogram when the ligament healed in the "attenuated position." (Ex. 54). Dr. Buehler further noted that the existence of the condition could be confirmed or denied by a "simple wrist arthroscopy." (Id.) In response to questions by the employer's attorney, Dr. Buehler subsequently reported that, because he had not examined the left wrist, he did not know whether it was hypermobile. (Ex. 56-1). He further stated that hypermobility was not the cause of claimant's symptoms but that claimant's symptoms could be secondary to a ganglion. (Id.) Finally, Dr. Buehler stated that the condition of scapholunate dissociation was the result of claimant's injury and that the ganglion was a result of the scapholunate dissociation. (Id.)

After reviewing the medical reports from Dr. Buehler, Dr. Nathan reported that his opinion had not changed that claimant's symptoms were caused by a ganglion rather than scapholunate dissociation. (Ex. 58). In rejecting the latter diagnosis, Dr. Nathan stated that dynamic x-rays "showed no difference in pattern of movement of the carpal bones" when comparing the right wrist to the left wrist, which was not consistent with an intercarpal ligament that had healed in an attenuated manner, as suggested by Dr. Buehler. (Id.) Dr. Nathan further indicated that there was no evidence of carpal instability demonstrated during the clinical examination. (Id.)

Dr. Appleby initially concurred with the diagnosis of scapholunate dissociation. (Ex. 53). Dr. Appleby then suggested a diagnosis of midcarpal instability. (Ex. 60). According to Dr. Appleby, the instability preexisted claimant's injury but, because he was asymptomatic before the injury and he landed on his right wrist in a hyperflexed manner, the work injury was the major contributing cause of his current need for treatment. (Exs. 74, 75, 77).

Dr. Woolpert also diagnosed bilateral midcarpal instability, as well as extensor tendinitis and strain of the right wrist, and a ganglion by history. (Ex. 76-4). Dr. Woolpert also noted that "most of [claimant's] problems" were "due to his work related activity." (Id. at 5).

Dr. Nathan disagreed with the diagnosis of extensor tendinitis but found that it was more consistent that the diagnosis of midcarpal instability. (Ex. 78). Following the ganglionectomy, Dr. Nathan reported that claimant's symptoms did not "appear to be secondary to the ganglion but to what may be a problem involving the carpal bones." (Ex. 82).

A claimant need not prove a specific diagnosis in order to prove compensability if he shows that his symptoms are attributable to work. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). In this case, although the physicians disagree regarding the correct diagnosis, all except Dr. Nathan support compensability. According to Dr. Buehler, claimant's work injury caused a scapholunate dissociation. His opinion would satisfy claimant's burden of proof under ORS 656.005(7)(a). Dr. Appleby opined that a preexisting condition combined with the work injury and that the work injury was the major contributing cause of claimant's need for treatment. Dr. Woolpert attributed claimant's conditions to his repetitive work activity. We find that both opinions satisfy the major contributing cause standard, whether under ORS 656.005(7)(a)(B) or 656.802(2).

Dr. Nathan's latest opinion indicated only that claimant's symptoms related to the "carpal bones" and did not specify the cause of the condition. Thus, we find that he provided no opinion regarding causation.

Therefore, we conclude that claimant proved compensability of his right wrist symptoms, whether diagnosed as scapholunate dissociation or midcarpal instability. Consequently, we affirm the Referee's order that set aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable fee is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated May 27, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
LEE SIGLER, Claimant
WCB Case No. 92-12949
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Schultz' order that set aside a Director's order which dismissed claimant's request for vocational assistance. On review, the issue is whether the Director's order is valid. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

We take administrative notice of the fact that on June 16, 1993, subsequent to Referee Schultz' January 21, 1993 order, the Director abated, withdrew, and amended his September 28, 1992 order. In his amended order, the Director found that he had failed to provide appeal rights in his original order and concluded that review of the order was to be to the Circuit Court rather than the Hearings Division. On that basis, the Director found that Referee Schultz' order was "without legal effect." With the addition of an appeal paragraph directing that any party aggrieved by the order may file a petition for review in the Circuit Court, the Director republished his September 28, 1992 order in its entirety.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that, by letter dated November 10, 1993, the employer submitted a copy of a June 16, 1993 Director's order and requested that we take administrative notice of that order. 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 the Director's June 16, 1993 order meets the aforementioned standard, we take administrative notice of it.

In his amended order, the Director found that he had failed to provide appeal rights in his original order and concluded that review of the order was to be to the Circuit Court rather than the Hearings Division. On that basis, the Director found that Referee Schultz' order was "without legal effect." With the addition of an appeal paragraph directing that any party aggrieved by the order may file a petition for review in the Circuit Court, the Director republished his September 28, 1992 order in its entirety.

In Marvin L. Thrasher, 45 Van Natta 565 (1993), and 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, we found that the requests for review concerning the extent of permanent disability were properly before the Board.

We find Thrasher, supra, and Moore, supra, analogous to the present situation where the Director subsequently abated and withdrew his order regarding the vocational dispute. See Steven B. Matthews, 45 Van Natta 1435 (1993). Issuance of the Director's subsequent order does not affect the Board's authority to review Referee Schultz' order regarding the Director's initial September 28, 1992 order.[1] In other words, the Director's action in abating, withdrawing, and amending his first order does

[1] Any issues arising from the Director's subsequent June 16, 1993 order are subject to initial review by the Hearings Division, should either party request a hearing. However, we note that, in his June 16, 1993 order, the Director used the same reasoning in deciding that there was no issue for review under ORS 656.283 as the Referee used in determining that the limited review set forth in ORS 656.283(2) did not apply to this case. Namely, both the Director and the Referee based their reasoning on the fact that the Director's initial order did not involve a substantive decision.

However, as discussed in the body of our order, ORS 656.283(2) provides no distinction between substantive and procedural determinations by the Director. By the same token that this absence of any distinction between substantive and procedural determinations does not take a Referee's review of a Director's order out of the limited

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Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable fee is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated May 27, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
LEE SIGLER, Claimant
WCB Case No. 92-12949
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Schultz' order that set aside a Director's order which dismissed claimant's request for vocational assistance. On review, the issue is whether the Director's order is valid. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

We take administrative notice of the fact that on June 16, 1993, subsequent to Referee Schultz' January 21, 1993 order, the Director abated, withdrew, and amended his September 28, 1992 order. In his amended order, the Director found that he had failed to provide appeal rights in his original order and concluded that review of the order was to be to the Circuit Court rather than the Hearings Division. On that basis, the Director found that Referee Schultz' order was "without legal effect." With the addition of an appeal paragraph directing that any party aggrieved by the order may file a petition for review in the Circuit Court, the Director republished his September 28, 1992 order in its entirety.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that, by letter dated November 10, 1993, the employer submitted a copy of a June 16, 1993 Director's order and requested that we take administrative notice of that order. 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 the Director's June 16, 1993 order meets the aforementioned standard, we take administrative notice of it.

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However, as discussed in the body of our order, ORS 656.283(2) provides no distinction between substantive and procedural determinations by the Director. By the same token that this absence of any distinction between substantive and procedural determinations does not take a Referee's review of a Director's order out of the limited scope of review provided by ORS 656.283(2), it also does not remove that review from the Hearings Division.

not disturb the Board's authority to consider the issues raised in that first order. Therefore, we proceed with our review of Referee Shultz' order regarding the Director's September 28, 1992 order.

Reasoning that ORS 656.283(2) did not apply, the Referee did not limit his scope of review. Instead, the Referee reviewed the Director's order de novo because the Director had dismissed claimant's request for Director review without reaching the merits of the claim. We disagree.

ORS 656.283(2) provides that the Director's decision concerning vocational assistance matters may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized by an abuse of discretion or clearly unwarranted exercise of discretion. The statute does not restrict the limitations on the review of a Director's order only to those orders based on substantive determinations. ORS 656.283(2).

In keeping with the absence of any distinction in ORS 656.283(2) between substantive and procedural determinations by the Director, the Board has consistently applied ORS 656.283(2) to cases in which a Director's order dismissed as untimely a claimant's request for review of an action by a carrier regarding vocational assistance. Larry D. Burleson, 45 Van Natta 950 (1993); James J. Kitchin, 44 Van Natta 532 (1992).[2]

Furthermore, the Supreme Court recently reaffirmed that review of a Director's order regarding vocational assistance is made pursuant to ORS 656.283. In doing so, the Court emphasized that, if no hearing is convened before the Director, the Referee is required to hold a hearing and develop a record, and that the Board reviews the Director's order based on the record made by the Referee. Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993).

Based on the above, we find that the scope of review of the Director's order in the present case is not de novo, but rather the limited review set forth in ORS 656.283(2). Applying that review standard, we nonetheless conclude that the Director's order must be modified.

On February 25, 1992, the vocational counselor sent claimant a certified letter notifying him that his eligibility for vocational services was being terminated effective February 25, 1992. The letter was sent to the wrong address and did not reach claimant until approximately March 4, 1993. This letter was not copied to claimant's attorney. By March 9, 1992, claimant's attorney had received a copy of the letter from claimant. On June 1, 1992, claimant's attorney requested initial administrative review of the termination of vocational services with the Rehabilitation Review Unit (RRU).

The Director found that "ORS 656.283 and OAR 436-120-210 require a worker to appeal a vocational assistance decision no later than the 60th day after the date the worker receives notification of the decision." (Ex. 10-2). Reasoning that claimant and his attorney had received notification of the employer's decision by March 9, 1992, the Director concluded that claimant's June 1, 1992 request for RRU review was untimely. Therefore, the Director concluded that the RRU did not have jurisdiction and affirmed the RRU's order of dismissal. Essentially, the Director concluded that "actual notice" to claimant's attorney was sufficient to begin the running of the time period within which to request Director review.

ORS 656.331(1)(b) provides that, if an attorney has given written notice of the attorney's representation of an injured worker, an insurer or self-insured employer "shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits."

Both ORS 656.283(2) and OAR 436-120-210(1) provide that, if a worker is dissatisfied with an insurer's or self-insured employer's action regarding vocational assistance, the worker must first seek Director's review of the matter before he or she may request a hearing. Both ORS 656.283(2) and OAR 436-120-210(1) also provide that the worker has 60 days from notification of the action to request Director review.

OAR 436-120-160 defines "Notices to Worker, Attorney and Department." OAR 436-120-160(3) lists the information that "[e]very notice stating the worker's ineligibility for vocational assistance,

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[2] Although these cases involve claimants who failed to timely request Director review of their vocational assistance disputes, these cases are distinguishable in that they do not involve the question of the effect of a carrier's failure to simultaneously notify the claimants' attorneys about the vocational assistance matter pursuant to ORS 656.331(1)(b), OAR 436-120-160(3), and OAR 436-120-210(1).

denying particular or further vocational assistance, or ending eligibility for vocational assistance" must contain. OAR 436-120-160(3) also states that "[p]ursuant to ORS 656.331(1)(b), copies of such notices shall be sent simultaneously to the worker's attorney." (Emphasis added).

Here, the February 25, 1992 "Notification Ending Eligibility for Vocational Assistance" was not simultaneously sent to claimant's attorney. ORS 656.331(1)(b); OAR 436-120-160. Furthermore, the employer does not contend that it was unaware of claimant's attorney's representation. (Exs. 3AA, 4A, 6A). However, the employer argues that the Director was correct in accepting the "actual notice" received by claimant's attorney from another source as sufficient to start the running of the 60-day period within which to request Director review of the employer's vocational action. We disagree.

Both the statute and the rules are clear and unambiguous. Moreover, none of these authorizes an exception for "actual notice" when the employer fails to simultaneously send notice to claimant's attorney as required. ORS 656.331(1)(b); OAR 436-120-160(3); OAR 436-120-210(1). Rather, the procedure for a notice made pursuant to ORS 656.283 is set out in OAR 436-120-160, and OAR 436-120-160(3) provides that a copy of such a notice shall simultaneously be sent to the worker's attorney pursuant to ORS 656.331(1)(b). Because a copy of the notification ending eligibility for vocational services was not simultaneously mailed to claimant's attorney, it is clear that that notification does not qualify as a valid "notice" pursuant to OAR 436-120-160(3).

In other words, "notice" under the Director's rule is defined as including a simultaneously sent copy to claimant's attorney. ORS 656.331(1)(b); OAR 436-120-160(3); OAR 436-120-210(1). Here, the vocational counselor's "notification" does not meet the definition of a valid "notice" because it was not simultaneously sent to claimant's attorney. ORS 656.331(1)(b); OAR 436-120-160(3); OAR 436-120-210(1).

The employer argues that the decisions in Freres Lumber Co. v. Jegglie, 106 Or App 27 (1991), and Thomas E. Edison, 44 Van Natta 211 (1992), support its contention that actual notice to claimant's attorney is sufficient to satisfy the requirements of the statutes and rules. We disagree and find both cases distinguishable.

Freres is distinguishable in that it dealt with a denial issued pursuant to ORS 656.262, which is subject to the "good cause" exception in ORS 656.319(1)(b). Here, ORS 656.283 does not include a "good cause" exception to the "60-day" appeal deadline. We adopt the Referee's reasoning and conclusions regarding that issue.

In any event, the decision in Freres did not hold that the 60-day appeal period was delayed until claimant's attorney received actual knowledge of the denial, as the employer contends. Instead, the court found that the claimant had established "good cause" for filing his request for hearing after the 60-day period expired but before the 180-day period expired on the basis that his attorney was not copied with the denial and did not have "actual knowledge of the denial" until after the 60-day appeal period had expired. Freres Lumber Co. v. Jegglie, supra at 30-31.

Our decision in Thomas E. Edison, supra, is also distinguishable. That decision was appealed to the court. SAIF v. Edison, 117 Or App 455 (1992). Although reversing on other grounds, the court agreed with our holding that, based on the 1990 amendments to ORS 656.262(8), the claimant's time to appeal the denial began running from the date of actual or constructive receipt of the denial. SAIF v. Edison, supra. This case does not support the employer's argument because the decision there relied on an interpretation of ORS 656.262(8), a statute that does not apply. Also, Edison did not involve a carrier's failure to provide written notice to the claimant's attorney pursuant to ORS 656.331(1)(b).

Here, the Director's order violates a statute or a rule in that it overlooks the requirements of ORS 656.331(1)(b) and OAR 436-120-160(3) which require the employer to give prior or simultaneous written notice to claimant's attorney regarding the termination of claimant's vocational services. Therefore, the Director's order must be modified. See ORS 656.283(2)(a).

We note that the Referee purported to remand the claim to the Director. However, the Referee's and the Board's authority is limited to modification of the Director's order. ORS 656.283(2). Erwin L. Farmen, 45 Van Natta 463 (1993); John R. Coyle, 45 Van Natta 325 (1993). Consequently, we modify the Director's order to provide that if the employer still contends that claimant is not eligible for vocational services, the employer must issue a "Notification Ending Eligibility for Vocational Assistance" that complies with the requirements provided by the relevant statutes and rules.

ORDER

The Referee's order dated January 21, 1993 is modified. The Director's September 28, 1992 order is modified to remand the claim to the employer for further action consistent with this order.

In the Matter of the Compensation of
DANIEL K. BEVIER, Claimant
WCB Case No. 91-15953
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Claimant requests reconsideration of our January 13, 1994 Order on Review which did not award claimant an assessed attorney fee under ORS 656.386(1). Claimant requests an assessed attorney fee in the amount of $3,600 for his counsel's services in setting aside the self-insured employer's "de facto" denial of medical services for his accepted phsychological condition.

In SAIF v. Allen, 124 Or App 183 (1993), the court reversed that portion of a Board order which awarded the claimant a carrier-paid attorney fee under ORS 656.386(1) for prevailing against a carrier's "de facto" denial of medical bills without a hearing. Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute." The Allen court concluded that inasmuch as the hearing pertained to the carrier's nonpayment of some medical bills and since the compensability of the claimant's injury was never disputed, claimant's attorney was not entitled to an attorney fee award under ORS 656.386(1).

The instant dispute concerned the compensability of medical treatment for an accepted psychological condition. Specifically, the employer contended that certain medical treatment was palliative and therefore not compensable, while claimant contended the treatment was curative and compensable, or alternatively, that it was compensable palliative care. (See Tr. 1-3). Compensability of the underlying psychological condition was not in dispute, nor was there a dispute concerning the causal relationship between the disputed treatment and the compensable condition. Furthermore, the employer never issued a formal denial of the disputed medical treatment. It did, however, write to claimant's treating physician advising that approval for palliative care would not be granted. (Ex. 2). Under these circumstances, we find that compensability of claimant's psychological condition was not in dispute at the hearing or on review in this case.

In accordance with the court's holding in Allen, we hold that an attorney fee may not be awarded under ORS 656.386(1) since the subject of the hearing was a dispute about payment of medical bills, rather than the compensability of claimant's psychological condition. Therefore, we conclude that claimant is not entitled to an assessed attorney fee under ORS 656.386(1).

Accordingly, on reconsideration, as supplemented herein, we republish our January 13, 1994 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Members Hall and Gunn dissenting.

Because we believe SAIF v. Allen, supra, is distinguishable and does not control the award of attorney fees in this case, we respectfully dissent.

ORS 656.386(1) provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

In Allen, the court was faced with a request for attorney fees under ORS 656.386(1) in a situation where the carrier failed to pay some medical expenses on a compensable claim until after the claimant requested a hearing regarding the nonpayment. The carrier paid the last of claimant's bills just before the hearing. The Board awarded an assessed attorney fee pursuant to the third sentence of ORS 656.386(1), because claimant's attorney had been instrumental in obtaining compensation without a hearing.

The Allen majority reversed the Board and held that "[b]ecause the compensability of claimant's injuries was not at issue in the hearing, her attorney was not entitled to an award of fees under ORS 656.386(1)." Allen, supra, 124 Or App at 186 (petition for review by Supreme Court filed January 5, 1994). The majority concluded that it was error to award an assessed attorney fee under ORS 656.386(1), "because the subject of the hearing was not the compensability of claimant's injuries. The hearing involved a dispute about payment of medical bills." Id.

Here, the dispute concerns compensability of medical treatment. The dispute does not concern merely the late payment of otherwise compensable medical bills, as apparently was the case in Allen. In the present case, the employer refused to pay medical expenses on the ground that they were incurred for noncompensable palliative care; the employer never conceded that the medical treatment was compensable. Here, unlike Allen, the employer was not merely late in paying medical expenses. Even though the carrier did not issue a formal, written denial, the carrier did not intend to pay the medical expenses, and never conceded that the expenses were compensable. Here, claimant prevailed over the employer's rejection of his claim for compensation for medical treatment only after a hearing and review by the Board. Thus, this situation is distinguishable from Allen, inasmuch as claimant here had to establish compensability of the medical treatment in order to secure compensation.

We agree with Judge DeMuniz that a "claim for compensation" under ORS 656.386(1) includes all benefits provided for a compensable injury, including medical services. See ORS 656.005(8); Allen, supra, 124 Or App at 188-89 (concurring opinion). Furthermore, we agree that a carrier's failure to timely accept or deny a claim ought to be considered a denial, which would entitle claimant to an attorney fee award under ORS 656.386(1) upon prevailing over the denial. 124 Or App at 187-190 (concurring opinion and J. Rossman, dissenting opinion); see also Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Thus, consistent with the concurring and dissenting opinions in Allen, we believe claimant in this case should be entitled to an assessed attorney fee under ORS 656.386(1), because he finally prevailed over the employer's denial of this claim for compensation.

Moreover, we do not believe the Allen decision, when limited to its particular facts, precludes the award of assessed attorney fees in this case. Rather, in cases such as this one, where a claimant must establish compensability of medical teatment, albeit neither compensability of the injury itself nor its causal relationship to medical treatment is challenged, a claimant who finally prevails is entitled to an assessed attorney fee under ORS 656.386(1).

In the Matter of the Compensation of
LEE A. BUSHNELL, Claimant
WCB Case No. 92-12334
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of Referee Baker's order setting aside its denial of claimant's bilateral inguinal hernia claim. The issue on review is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his ultimate finding that claimant's work activity for the employer was the major contributing cause of his bilateral inguinal hernia. We make the following additional findings. The sharp left groin pain claimant experienced at the time of his April 27, 1992 lifting incident resolved within a few minutes. Claimant first noticed a bulging in his left groin area in late May 1992.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that his condition was compensable as an injury or an occupational disease. The Referee found the condition compensable as an occupational disease, relying on the combined effect of claimant's work activity, including the alleged lifting incident in late April 1992. The Referee relied on the opinion of Dr. Gerstner, who began treating claimant's hernia condition in November 1992. Dr. Gerstner opined that claimant's April 1992 lifting incident and general work activity was the major cause of his bilateral hernia condition.

Dr. Gerstner's opinion assumed a history of continuing sharp left groin pain since the April 1992 lifting incident, and the appearance of a left groin bulge within a few days of the incident. (Exs. 5, 6, 8). This history was supplied by claimant's attorney and is not consistent with Dr. Weeks' report that claimant's sharp left groin pain resolved within a few minutes of the lifting incident. (Ex. 4). Nor is the history relied on by Dr. Gerstner consistent with claimant's own testimony. Claimant testified that Dr. Weeks' account of claimant's symptoms was accurate. (Tr. 41). Claimant further testified that he first noticed a bulging in the left groin no more than one week before he saw Dr. Weeks on June 1, 1992 -- not within a few days of the April 27, 1992 lifting incident as Dr. Gerstner assumed. (Tr. 46).

On this record, we conclude that Dr. Gerstner based his opinion on an inaccurate history of claimant's symptoms. Moreover, we cannot determine whether Dr. Gerstner would have reached the same opinion based on claimant's actual symptoms as reported by Dr. Weeks and testified to by claimant. There is no other medical opinion in the record supporting compensability. Accordingly, we conclude that claimant has not carried his burden of proving that his hernia condition is compensable as an injury or an occupational disease.

ORDER

The Referee's order dated June 17, 1993 is reversed. The insurer's denial is reinstated and upheld.

In the Matter of the Compensation of
JIMMIE G. CLARK, Claimant
WCB Case No. 91-13121
ORDER ON REVIEW
David C. Force, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Referee Lipton's order that: (1) affirmed the Determination Order awards of temporary disability benefits and 28 percent (89.6 degrees) unscheduled permanent disability benefits for a low back condition; and (2) awarded claimant's attorney an assessed fee of $9,685 for prevailing against the employer's hearing request from the Determination Order. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to order the employer to pay temporary disability and permanent disability benefits awarded by the Determination Order pending its appeal of that award; (2) declined to assess a penalty for the employer's allegedly unreasonable refusal to pay the Determination Order awards pending its appeal; and (3) declined to assess a penalty under ORS 656.382(3). On review, the issues are temporary disability, extent of unscheduled permanent disability, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Permanent disability

The Referee affirmed the Determination Order award of 28 percent unscheduled permanent disability benefits.[1] In doing so, the Referee declined to consider the employer's argument that the back condition rated in the Determination Order is unrelated to the compensable low back injury, explaining that the same argument was considered and rejected in prior litigation. We adopt the Referee's findings and conclusions concerning this issue.

Temporary disability

The employer also challenges the Determination Order award of temporary total disability benefits for the period from October 2, 1989, through January 25, 1990, less any time worked. The employer argues that claimant's inability to work beginning in mid-November 1989 was due to hospitalizations unrelated to the compensable injury. We disagree.

Claimant is substantively entitled to temporary disability benefits for the period that he was disabled due to the compensable injury before becoming medically stationary. See ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Contrary to the employer's contention, we find sufficient evidence in the record to show that claimant was disabled due to the compensable injury until he became medically stationary on January 25, 1990.

Claimant was compensably injured on October 2, 1989, when he was struck twice in the back by a floor buffer while waxing floors. He left work and went to the emergency room the next day. Dr. Winner diagnosed low back contusion and released claimant from work. (Ex. 4). On October 6, 1989, claimant began treating with Dr. Huff, who also released him from work. (Ex. 7).

In November 1989, claimant fell on three different occasions and sought treatment for low back pain following each incident. By Opinion and Order on Remand dated July 2, 1992, Referee M. Johnson found that the falls in November 1989 were compensably related to the October 2 injury. (Exs. 42, 56). That order was affirmed by the Board on March 11, 1993.

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[1] Claimant became medically stationary on January 25, 1990. Inasmuch as claimant became medically stationary before July 1, 1990, the mandatory reconsideration procedure in amended ORS 656.268(5) does not apply in this case. See Or Laws 1990 (Special Session), ch 2, § 54(3). Therefore, the Referee properly had authority to review the Determination Order.

Following his third fall, claimant received a further release from work due to back pain on November 30, 1989. (Ex. 34). On December 21, 1989, Dr. Huff again released claimant from work. (Ex. 37). In doing so, he did not indicate when claimant would be able to return to work.

There is no further evidence concerning claimant's ability to work prior to becoming medically stationary on January 25, 1990. On January 23, 1990, Dr. Huff wrote that claimant's compensable injury "is not of a nature to cause as much subjective complaints as we have seemed to have found." (Ex. 39). However, Dr. Huff did not release claimant for work nor did he withdraw his prior opinion that claimant was unable to work due to the compensable injury.

After reviewing this record, we find that a preponderance of the evidence proves that claimant was disabled due to the compensable injury for the period from October 2, 1989 through January 25, 1990. In this regard, we reject the employer's argument that claimant is not entitled to temporary total disability benefits for the period that he was hospitalized for drug and alcohol treatment in November 1989. Although claimant's hospitalization in November 1989 was not for reasons related to his compensable injury, he had been released from work by Dr. Huff prior to that hospitalization, and there is no evidence that claimant was subsequently able to work due to the compensable back condition prior to January 25, 1990. Accordingly, we affirm the Determination Order.

Attorney Fees

The Referee awarded claimant's attorney an assessed fee of $9,685 for services rendered at hearing in prevailing against the employer's hearing request from the Determination Order. The employer contends that the fee award is excessive. We agree.

Claimant's attorney is entitled to an assessed fee for prevailing against the employer's hearing request concerning the permanent disability and temporary disability issues. See ORS 656.382(2). A reasonable amount for the attorney fee is determined based on the following factors: (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 proceeding; (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. OAR 438-15-010(4).

Claimant's entitlement to compensation turned on the causal relationship between the compensable injury and his temporary and permanent disability. The hearing proceedings did not require extensive participation by claimant's attorney. The first hearing in May 1992 lasted 50 minutes and was continued pending the outcome of litigation concerning compensability. The reconvened hearing in October 1992 lasted one hour and 25 minutes. No witnesses testified, and no depositions were taken. All exhibits were offered into evidence by the employer.

Claimant's attorney represented to the Referee that he spent 74.5 hours defending against the employer's hearing request. We do not question the accuracy of such a representation. Nevertheless, the time devoted to the case is only one of several factors considered in determining a reasonable fee. See generally Anthony Foster, 45 Van Natta 1997 (1993) (on reconsideration).

Moreover, we note that claimant also filed a cross-request for hearing raising additional issues concerning the employer's failure to pay compensation awarded by the Determination Order. Claimant's attorney is not entitled to an assessed fee for services concerning those issues. Claimant's attorney presumably rendered services at hearing concerning its cross-request for hearing; yet, there is no explanation in the record of how many hours were spent on those issues, as opposed to the issues raised by the employer.

We recognize that the value of the interest involved in this case is substantial. The Determination Order challenged by the employer awarded approximately $11,000 in compensation. Finally, there was a substantial risk that claimant's attorney might go uncompensated for his services, particularly given the evidence concerning claimant's history of drug abuse.

After considering these factors, we find that a reasonable fee for claimant's attorney's services at hearing concerning the temporary disability and extent of permanent disability issues is $5,500. We modify the Referee's assessed fee award accordingly.

Stay of Compensation

Claimant seeks the assessment of a penalty for the employer's allegedly unreasonable refusal to pay compensation awarded by the Determination Order. He argues that the employer was required to pay all compensation awarded by the Determination Order. We disagree.

As a preliminary matter, we note that the employer's payment ledger reflects that it paid virtually all of the temporary total disability compensation awarded by the Determination Order. (Ex. 57). Even if those benefits had not been paid, we would find that all of the compensation awarded by the Determination Order was properly stayed under ORS 656.313.

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."

In Felipe A. Rocha, 45 Van Natta 47 (1993), we held that, under ORS 656.313(1)(a), a carrier's appeal of an order finding a claim compensable stays "pre-litigation order" temporary disability awarded on the claim by a notice of closure or determination order. See Diamond Fruit Growers v. Goss, 120 Or App 390, 393-94 (1993) (citing with approval the Board's holding in Rocha). We have also held that a carrier's appeal of a compensability determination stays any permanent disability awarded by a notice of closure or determination order. See Dale E. Holden, 45 Van Natta 354 (1993).

Here, when the Determination Order issued on August 12, 1991, the employer had a pending request for Board review concerning Referee M. Johnson's February 20, 1991 order finding the injury claim compensable. (Ex. 42). Inasmuch as the employer was appealing the compensability determination, the payment of all compensation awarded by the Determination Order was stayed pursuant to ORS 656.313.

On November 11, 1991, the Board issued its order vacating Referee Johnson's order and remanding the case for the taking of additional evidence. (Ex. 51). The Board's action effectively extinguished the employer's obligation to pay compensation pursuant to Referee Johnson's order. Thereafter, by Opinion and Order on Remand dated July 2, 1992, Referee Johnson considered the additional evidence, and adhered to and republished his earlier order finding the claim compensable. (Ex. 56). The employer requested Board review of that order. The request for Board review remained pending at the time the record in this case was closed on March 1, 1993. Subsequently, on March 11, 1993, the Board affirmed Referee Johnson's July 2, 1992 order.

Hence, at the time the record was closed in this case, the employer was appealing Referee Johnson's compensability determination. We conclude that that appeal stayed the payment of all compensation awarded by the Determination Order. See Felipe A. Rocha, supra; Dale E. Holden, supra. Accordingly, we do not find that the employer's refusal to pay the compensation was unreasonable. No penalty is warranted under ORS 656.262(10)(a).

Penalties

Finally, claimant seeks the assessment of a $750 penalty under ORS 656.382(3), contending that the employer initiated the hearing in this case "for the purpose of delay or other vexatious reason or without reasonable ground." We deny the request.

ORS 656.382(3) provides:

"If upon reaching a decision on a request for hearing initiated by an employer it is found by the referee that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the referee may order the employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances."

Even if we had such authority, we would decline to do so on the merits. The employer submitted medical evidence to show that claimant had a serious chemical dependency which prompted some doctors to question the reliability of his pain complaints. Further, claimant was hospitalized for drug and alcohol treatment unrelated to the compensable injury while his claim was in open status. Under these circumstances, we find that the employer had a reasonable ground for contesting the Determination Order awards of temporary disability and permanent disability benefits.

Attorney Fee on Board Review

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 and extent of unscheduled permanent disability issues is $812.50, to be paid by the self-insured 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 March 10, 1993 is modified in part and affirmed in part. The Referee's assessed fee award for services at hearing is reduced to $5,500, to be paid by the self-insured employer. The remainder of the order is affirmed. Claimant's attorney is awarded $812.50 for services on Board review, to be paid by the employer.

February 9, 1994 Cite as 46 Van Natta 221 (1994)

In the Matter of the Compensation of
GARY C. FISCHER, Claimant
WCB Case No. 91-08489
ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant has requested reconsideration of our January 14, 1994 Order on Review. Specifically, claimant contends that we erred in finding that Exhibit 14 (a September 26, 1991 "post-reconsideration order" medical report from the attending physician) was not relevant in determining the extent of his scheduled permanent disability. In support of his contention, claimant has submitted a March 3, 1992 medical report from Dr. Rich, his attending physician. We treat claimant's submission as a request for remand. Judy A. Britton, 37 Van Natta 1262 (1985). After considering claimant's motion and memorandum in support, we issue the following order.

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). A compelling basis 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).

The original hearing in this matter was held on September 30, 1991. Claimant's hearing request was dismissed for lack of jurisdiction. On review, we reinstated claimant's hearing request and remanded the matter to the Referee for the taking of testimony relative to the extent of permanent disability issue. Gary C. Fischer, 44 Van Natta 1597, on recon 44 Van Natta 1655 (1992). In addition, we noted that Exhibit 14 was not admissible pursuant to ORS 656.268(5) because it was generated after the Order on Reconsideration. Id.

Inasmuch as we remanded this case only for the taking of testimony, claimant was essentially precluded from presenting any additional documentary evidence at the "remand" hearing. Nevertheless, the issue is whether claimant could have obtained the proferred evidence with due diligence prior to the original September 30, 1991 hearing. We find that the evidence was obtainable with due diligence and therefore remand is not merited.

Although the medical report offered by claimant was generated some 6 months after the original hearing, it is from Dr. Rich, claimant's attending physician, whose previous reports are in the record. In addition, the medical report does not concern claimant's condition after the September 30, 1991 hearing, but rather is a clarification of Exhibit 14, the September 26, 1991 report which was offered by claimant and ultimately admitted by our Order on Review. Since the report represents further explanation of a report that was authored prior to the hearing, the clarification was clearly obtainable with due diligence by the time of hearing. Under these circumstances, we conclude that remand is not warranted and decline to grant claimant's request.

Finally, we note that claimant contends that the Board's finding that Exhibit 14 was not relevant was not raised by the parties and should be reversed. While the original basis for excluding the document was ORS 656.268(5), we are mandated to evaluate claimant's permanent disability as of the time of the reconsideration order. ORS 656.283(7); 656.295(5); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The relevance of Exhibit 14, since it was generated and based on an examination that occurred subsequent to the reconsideration, is an inquiry that is necessary in order for the Board to meet its statutory obligation. Thus, although not specifically raised by the parties, it is a function that a referee or the Board must perform in any case when weighing the medical evidence to determine the issue before it, i.e., the extent of claimant's permanent disability.

Accordingly, our January 14, 1994 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 run from the date of this order.

IT IS SO ORDERED.

February 9, 1994 Cite as 46 Van Natta 222 (1994)

In the Matter of the Compensation of
FRED KUYKENDALL, Claimant
WCB Case No. 93-00661
ORDER ON REVIEW
Michael B. Dye, P.C., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Garaventa's order that upheld the SAIF Corporation's denial of claimant's medical services claim for a low back condition. Claimant argues that the denial is precluded by a prior referee's order which set aside a denial of claimant's then-current medical treatment for his low back condition. On review, the issues are issue preclusion and medical services (compensability). We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

The current claim is for surgery for removal of a disc and/or decompression at L2-3, L4-5 bilaterally and possibly at L5-S1 on the right. (Ex. 30-4).

On June 23, 1988, a prior referee set aside SAIF's denial of claimant's claim for medical services for his then-current low back condition, which was a lumbosacral strain superimposed on degenerative changes. The prior referee found that claimant's 1973 compensable back injury (strain) was a material contributing cause of his need for medical services at that time. (See Exs. 23, 24).

There is some evidence that degenerative changes preexisted claimant's 1973 compensable strain (Exs. 5, 6-2, 8-2) and there is evidence that claimant now suffers from severe degenerative spinal changes (for which surgery is now requested) which have developed since the 1973 injury. (Exs. 27-1, 30-3, 31-6, 34). There is no evidence that these subsequent spinal changes were directly caused by the 1973 accident which caused the strain.

CONCLUSIONS OF LAW AND OPINION

Preclusion

The Referee upheld SAIF's denial of claimant's claim. Relying on ORS 656.005(7)(a)(B), the Referee reasoned that claimant failed to establish that the accepted 1973 injury is the major contributing cause of claimant's current need for medical services for his low back.

Claimant argues that SAIF is precluded from denying his current claim for medical services. Specifically, he reasons that the claim is for continuing medical services for the same condition which was previously litigated and determined compensable by a 1988 Opinion and Order. (See Ex. 23). Thus, claimant contends that SAIF's denial is barred by the doctrine of res judicata, specifically issue preclusion.

In Drews v.EBI, 310 Or 134 (1990), the Supreme Court stated:

> "The issue preclusion branch of preclusion by former adjudication, formerly called collateral estoppel, precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached. * * * This court has previously explained issue preclusion as follows:
>
> "'If a claim is litigated to a final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment.'" Drews, supra at 139-140 (citations omitted).

The key elements of issue preclusion are: the same parties; a valid and final judgment; actual litigation of an issue of fact or law; and a determination of that issue which is essential to the judgment. See Restatement of Judgments, Section 27 (1980).

In this case, the parties are the same as in the prior litigation. The prior litigation culminated in a final valid judgment when the 1988 Opinion and Order was not appealed. The remaining questions are whether the issue litigated at the 1993 hearing is actually the same as the one previously adjudicated and, if so, whether determination of that issue was essential to the earlier judgment.

Claimant contends that the present issue is the same as it was in 1988, i.e., compensability of his current low back condition. We disagree.

Claimant's initial diagnosis following his 1973 work injury was "acute lumbosacral strain." (Exs. 1, 3). The 1973 Notice of Acceptance simply listed "Back." (Ex. 2). X-rays revealed minimal lumbosacral osteoarthritis, with incipient degenerative changes elsewhere. (Exs. 5, 6-2). By June 1974, claimant's diagnosis was "back strain superimposed on some degenerative disc changes at L5." (Exs. 8-2). The initial claim was closed by a January 7, 1975 Determination Order which awarded 35 percent unscheduled permanent disability for the low back injury. (Ex. 11).

In 1987, claimant sought additional conservative treatment and, through his chiropractor, sought reopening of his claim due to an aggravation of his condition. (Exs. 15, 16). SAIF issued two denials: a denial of aggravation based on the contention that claimant's condition had not worsened since the claim was previously closed (Ex. 19) and a second denial based on the contention that there was no causal connection between claimant's 1973 injury and ". . . your present need for treatment." An April 1988 hearing was held. The prior referee identified the issue as claimant's appeal from SAIF's denial of "responsibility for continuing ORS 656.245 medical treatment."[1] (Ex. 23-1). The referee noted that claimant's degeneration had progressed over time. However, based on claimant's credible testimony

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[1] Ultimately, claimant did not contest the denial of aggravation (which was then affirmed) because his aggravation rights had expired in 1980. (Ex. 24).

regarding his continuing symptoms and the opinion of Dr. Moore (treating physician), the referee concluded: "I am persuaded . . . that a material relationship between claimant's current need for treatment and the original injury still exists." (Ex. 23-3). (Emphasis added). Accordingly, the referee set aside SAIF's medical services denial. (Ex. 23-4).

Based on the above, we conclude that the compensability of claimant's then-current need for particular medical services was claimed, actually litigated and finally determined to be compensable by the 1988 referee's order. However, in resolving the 1988 medical services dispute, the referee only determined that claimant's compensable condition was a material cause of his then-current need for conservative medical services. The parties did not raise or litigate and the Referee did not determine (actually or necessarily) the compensability of claimant's then-current degenerative condition. (See Ex. 23).

The present issue is whether claimant's current claim for medical services (a request for surgery at L2-3, L4-5 and L5-S1) is compensable.

Drs. Tiley, Melgard, Englander and Ayers agree that claimant currently suffers from active progressive disc degeneration, a condition which has changed over time. (Exs. 27-1, 30-3, 31-6, 34-1). Specifically, his current diagnosis is advanced lumbar spondylosis with stenosis. (Ex. 33B). On this evidence, we find that claimant's current condition is not the same as the lumbosacral strain, superimposed over minimal degeneration, which he had in 1988. Thus, the issue now is not the same as the issue previously litigated and SAIF's denial of the current claim for medical services is not barred by the doctrine of issue preclusion. See Deborah K. Brickley, 45 Van Natta 145 (1993).

Claimant also argues that SAIF may not "relitigate" the compensability of claimant's condition, based on Cox v. SAIF, 121 Or App 568 (1993). We find Cox distinguishable. In Cox, relitigation of the compensability issue was barred because compensability of specific conditions had been finally litigated (favorably to the claimant), under the material contributing cause standard by the time the 1990 statutory amendments to Workers' Compensation law imposed a major contributing cause standard upon consequential conditions. See ORS 656.005(7)(a)(A). In Cox, the carrier was barred from relitigating the same issue (the same claim) in order to impose the major contributing cause standard. Here, in contrast, as discussed above, the claim now presented by claimant is not the same issue or claim litigated in 1988.

Medical services/compensability

We adopt the Referee's "Conclusions and Opinion" on the merits, with the following supplementation.

The Referee applied ORS 656.005(7)(a)(B), and analyzed the claim as one involving a preexisting condition. There is some evidence to support the existence of back degeneration preexisting the 1973 compensable injury. (See Exs. 5, 6, 8, 23-3, 34).

Nevertheless, we need not resolve that question because, even if ORS 656.005(7)(a)(B) was not applicable, claimant would still be required to prove that his 1973 compensable injury was the major contributing cause of his "consequential condition." (Since the record does not support a finding that claimant's degenerative condition arose directly from the 1973 industrial accident). In other words, whether analyzed under section (7)(a)(B) or (7)(a)(A), claimant's current degenerative condition would not be compensable.

ORDER

The Referee's order dated April 29, 1993 is affirmed.

In the Matter of the Compensation of
BRIAN G. VOGEL, Claimant
WCB Case No. 91-12115
ORDER ON RECONSIDERATION
Galton, et al., Claimant Attorneys
Priscilla Taylor, Defense Attorney

Claimant requests reconsideration of that portion of our January 18, 1994 Order on Review that awarded him 5 percent (7.5 degrees) scheduled permanent disability award for loss of use or function of the right forearm. Claimant seeks an increased award based on loss of strength. Alternatively, claimant requests that his claim be remanded to the Director for adoption of a temporary rule amending the standards to address his loss of strength.

Our prior order adequately addresses claimant's contention that he is entitled to an award for loss of strength under the existing standards. Claimant's loss of strength is not ratable under the existing standards for rating permanent disability.

We have the authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. See Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). Inasmuch as the standards include a rule which addresses loss of grip strength, it is arguable whether this is an appropriate claim to remand to the Director for adoption of a temporary rule. However, we need not address that question because claimant did not preserve this issue for our review.

Unlike the worker in Gallino, claimant did not request the Director to adopt a temporary rule. Claimant also failed to make a remand request either to the Referee at hearing or to the Board on review. Rather, claimant's remand request is made for the first time on reconsideration of our order. We do not consider issues raised for the first time on review or reconsideration. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Kenneth D. Nichols, 45 Van Natta 1729 (1993).

Accordingly, we withdraw our January 18, 1994 order. On reconsideration, as supplemented herein, we adhere to and republish our January 18, 1994 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
ROBBIE W. WORTHEN, Claimant
WCB Case No. TP-93011
THIRD PARTY DISTRIBUTION ORDER
G. Jefferson Campbell, Claimant Attorney
Schwabe, et al., Defense Attorneys

The paying agency, Lumberman's Underwriting Association (hereafter referred to as LUA), on behalf of Westbrook Wood Products, has petitioned the Board for resolution of disputes concerning the distribution of proceeds arising from a third party wrongful death case. See ORS 656.593(1) & (3). More specifically, LUA contends that: (1) it is entitled to a share of the proceeds arising from the settlement agreement entered into between the personal representative of the Robbie W. Worthen estate (hereafter referred to as claimant) and a third party, D-9 Construction (hereafter referred to as D-9), in the amount of $6,115.45; and (2) it is entitled to a share of the judgment proceeds arising from a civil court case between claimant and another third party, Navistar International (hereafter referred to as Navistar), in the amount of $8,747.74, or, in the alternative, $6,162.85.

Claimant cross-petitions the Board for resolution of the following issues: (1) a determination that all proceeds arising out of the third party wrongful death case are not subject to any lien of LUA; (2) a finding of extraordinary circumstances allowing for an extraordinary attorney fee equal to 40 percent of any and all third party settlement/judgment proceeds in accordance with the executed retainer agreement and order of the probate court (PR Ex. 4); and (3) entitlement to an award of attorney fees for filing and prosecuting this petition before the Board under ORS 656.382(2) and/or under the equitable doctrine of the preservation of a common fund.

We hold that LUA is entitled to a lien amount of $6,115.45 against the D-9 settlement proceeds. LUA is not entitled to a share of the Navistar judgment proceeds. Moreover, we do not find claimant's counsel is entitled to an extraordinary attorney fee in excess of 33 1/3 percent of the recovery from either the settlement proceeds or the judgment proceeds. Finally, we do not find a basis in law for awarding claimant's counsel an attorney fee for filing and prosecuting this petition.

FINDINGS OF FACT

On June 24, 1988, the deceased worker was killed when the log truck he was driving rolled over crushing the cab of the truck. A workers' compensation claim was filed by the decedent's beneficiary, his wife. The claim was accepted by the workers' compensation insurer for the employer, LUA, who has paid, and continues to pay, benefits.

The decedent's widow was appointed to be the personal representative of the estate. Thereafter, claimant (as personal representative of the estate) pursued the possibility of a third party action. Claimant initially was represented by another attorney, but he was subsequently discharged. Thereafter, she sought, without success, other counsel to represent her. (PR Ex. 3). On June 13, 1991, she retained her present counsel, who, in turn, secured special counsel to assist in the litigation of the product liability aspects of the pending lawsuit. (PR Exs. 3, 4).

On June 21, 1991, a complaint was filed in Coos County Circuit Court against D-9 (the company responsible for loading the truck) for negligence, Navistar (the manufacturer of the truck) and Northwest (distributor of the truck) for product liability, breach of warranty, and manufacturing negligence.

On September 4, 1991, claimant filed an election with LUA to recover damages from third parties pursuant to ORS 656.593(1).

Prior to the trial, claimant and D-9 entered into a settlement agreement for $15,000. The agreement was approved by the trial court on April 30, 1992. It was the intent of claimant to use these proceeds to fund the litigation expenses for the pending trial against Navistar and Northwest. LUA, however, was not interested in funding litigation expenses of the pending trial. Consequently, LUA demanded its statutory share of the D-9 settlement proceeds and requested an accounting of the claim costs. Claimant responded with providing LUA with an October 7, 1991 statement in the amount of $826.82. (LUA Exs. 12, 13, 14).

On June 10, 1992, the complaint was amended to exclude D-9 as a defendant at trial. On July 27, 1992, the jury trial commenced against Navistar and Northwest. The trial lasted three weeks. There were 339 exhibits submitted to the court, and 30 witnesses, 6 of which were expert witnesses.

Claimant was successful against Navistar on the theory of manufacturing negligence and was awarded a judgment of $97,592.91. However, the jury further found that claimant was 50 percent contributory negligent. Thus, the judgment was reduced to $48,796.46. The trial judge further reduced the award granting Navistar a "settlement credit" in the form of a contribution claim for the D-9 settlement of $15,000 for a total award of $33,796.46. (LUA Ex. 10-5).

Claimant submitted a cost bill to the court on September 22, 1992 in the amount of $13,396.02. Navistar objected to this amount. After a hearing before the trial judge on November 3, 1992, claimant's counsel was awarded "costs and disbursements" of $7,677.99. See ORCP 68.

A final judgment was entered on January 7, 1993. The judgment amount, including court costs and accrued "post-judgment" interest was $42,343.64. (LUA Exs. 23, 24, 25).

LUA's lien consists of $60,315.63 in actual claim costs and $349,509.37 in projected claim costs, for a total of $409,825.

ULTIMATE FINDINGS OF FACT

The settlement with D-9 Construction and the Navistar trial verdict constituted separate causes of action by claimant against separate third parties.

The settlement of the D-9 claim did not present extraordinary circumstances warranting an attorney fee in excess of one third of the settlement amount.

The Navistar litigation did not present extraordinary circumstances warranting an attorney fee in excess of one third of the judgment proceeds.

Claimant's costs in association with the D-9 Construction settlement were $826.82.

Claimant's costs in association with the Navistar litigation, in addition to court costs, was $55,544.32.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to negligence or wrong of third persons not in the same employ, the worker or the beneficiaries of the worker shall elect whether to recover damages from the third persons. The proceeds shall be subject to a lien of the paying agency for its share of the proceeds. The statutory formula for distribution of a third party recovery obtained by judgment is set forth in ORS 656.593(1).

Settlement proceeds are to be distributed in a manner determined to be "just and proper." ORS 656.593(3). The statutory formula for distribution of third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. 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 Karen A. King, 45 Van Natta 1548, 1551 (1993) (citing Marvin Thornton, 34 Van Natta 999, 1001 (1982)).

The structure of ORS 656.593 is that costs and attorney fees incurred shall be initially disbursed, such attorney fees in no event to exceed the advisory schedule of fees established by the Board for such actions. ORS 656.593(1)(a).

Thereafter, the worker shall receive at least 33 1/3 percent of the balance of recovery. ORS 656.593(1)(b). After those deductions, the paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the workers' claim under the workers' compensation law. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d); Liberty Northwest Ins. Corp. v. Golden, 116 Or App 64, 67-68 (1992).

Cause of Action

At issue here is whether or not LUA has a viable lien. In this regard, ORS 656.580(2) provides that "the paying agency has a lien against the cause of action as provided by ORS 656.591 and 656.593, which lien shall be preferred to all claims except the cost of recovering such damages." ORS 656.580(2) (emphasis supplied).

It is LUA's contention that the settlement with D-9 and the lawsuit against Navistar each represent a separate "cause of action." In support of its position, LUA points to the fact that each claim involved different parties, were resolved at different times, and resulted in different recoveries. Therefore, LUA argues, distribution of the proceeds should be made separately. In response, claimant argues that there was but one factual transaction, one lawsuit, and hence only one "cause of action." Therefore, claimant contends proceeds should be combined and distribution based on total proceeds.

Historically, a cause of action has generally been defined as "an aggregate of operative facts which compose a single occasion for judicial relief." Dean v. Exotic Veneers, Inc., 271 Or 188, 192-193, 196 (1975) (citing Clark on Code Pleading 472-78 (2d ed 1947). Current pleading practices refers to "A plain and concise statement of the ultimate facts constituting a claim for relief." ORCP 18A. Recently, in Holger v. Irish, the Supreme Court stated that "claim for relief" has replaced "cause of action" as a term of art in pleadings. However, the Court also took the view that a "claim for relief" was narrower than "cause of action" because the Oregon rules require a pleader to state "the ultimate facts constituting a claim for relief rather than pleading a form of action." See Holger v. Irish, 316 Or 402, 406-407 (1993) (citing State ex rel Gattman v. Abraham, 302 Or 301, 310 n. 6 (1986).

Our review of the extensive case law on this subject indicates that whether or not there is one or more "cause of action" depends on the underlying facts, the theories plead, and the defendants involved. Compare McGrath v. White Motor Corp., 258 Or 583 (1971)(negligence and implied warranty claims are part of the same cause of action but should be stated separately); Blake v. Webster Orchards, 249 Or 348 (1986)(plaintiff must allege negligence and strict liability as separate cause of actions). Ultimately resolution of this issue is a factual matter.

After our review of this case, we conclude there were two separate causes of action. The first cause of action was primarily a product liability, breach of warranty, and manufacturing negligence action against Navistar and Northwest. The operative facts involved the dangerously defective manufacture by Navistar of the truck and arose when the truck was sold on July 1, 1987 to the decedent's employer. The second cause of action was a negligence action against D-9. The operative facts there occurred approximately two years later and involved the alleged negligent loading of the truck by D-9 on the day of the accident, June 24, 1989. (See PR Ex. 5 initial complaint; PR Ex. 25 amended complaint filed after settlement approved and deleting the "claims for relief" against D-9).

The operative facts for the product liability, breach of warranty, and manufacturing negligence action when compared with the operative facts for the negligence action are distinctly different and arose at different times. The theories of recovery are also fundamentally different. Compare Erickson Air-Crane Co. v. United Tech. Corp., 303 Or 281, 289 (1987). Moreover, we note the defendants involved, Navistar and D-9, are different and unrelated. Finally we note that claimant pled and treated these theories as separate claims for relief. (See PR Exs. 5, 25). We therefore conclude that the negligence action and product liability action can not be the same transaction, and therefore, can not be considered a single cause of action. Compare Horn v. City of Elgin, 28 Or App 545, 547-548 (1977). Accordingly, we find the settlement with D-9 and the lawsuit against Navistar each represent a separate "cause of action."

In support of her position that there existed but one cause of action, claimant explains that the function of the D-9 settlement was two-fold: (1) to reimburse the decedent's widow for monies she had already lent to the estate to fund litigation; and (2) to pay for future expected litigation expenses. In this way, claimant argues, she would be better able to ultimately prevail against "deeper pockets," namely, Navistar and Northwest. The record is persuasive that that was claimant's intent and that this intent was made clear to LUA. (PR Exs. 13, 14, 17). However, LUA never consented to waive its lien on the D-9 settlement proceeds. Instead, LUA asked for an accounting of the costs and made specific demand for its lien. (PR Exs. 15, 16, 18, 22).

Claimant also points to the fact that the trial court reduced the judgment amount assessed against Navistar by the D-9 settlement amount of $15,000. (PR Ex. 35-4). Claimant argues that this is evidence of one "cause of action." ORS 18.455(1)(a) provides that a plaintiff's settlement with some but not all of the defendants in a case reduces the claim against the remaining defendant(s) to the extent of the amount of the settlement. The trial court is tasked with accomplishing this "settlement credit function." See Yardley v. Rucker Brothers Trucking, Inc., 42 Or App 239, 242-243 (1979).

As used in this case, ORS 18.455, is applied to determine the money judgment to be awarded. It does not address or answer the question before us, namely, whether or not there was one or two causes of actions for the purposes of making a third party distribution. Accordingly, for the foregoing reasons, we consider the D-9 settlement proceeds separately from the Navistar judgment proceeds.

Costs

ORS 656.593(1)(a) provides that costs and attorney fees incurred in the third party action shall be initially paid from the third party recovery. OAR 438-15-005(6) provides:

> "Costs" means money expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, but do not include fees paid to any attorney. Examples of costs referred to include, but are not limited to, costs of independent medical examinations, depositions, expert witness opinions, witness fees and mileage paid to execute a subpoena, and costs associated with travel."

D-9 Settlement

It is the position of LUA that claimant is entitled to costs in the amount of $826.82 for obtaining the D-9 settlement. This position is based on a statement provided by claimant's counsel in direct response to LUA's request for an accounting of costs attributable to the D-9 claim. (LUA Ex. 13). Claimant's position is that it is impossible to allocate costs between the D-9 claim and the Navistar claim. Instead, claimant would argue for a total combined costs of $56,371.14. (LUA Ex. 20). In the alternative, assuming the Board considers the D-9 claim as a separate cause of action, claimant asks for costs in the amount of $24,454.37. (Claimant's cross-petition, pages 12-15; Affidavit of G. Jefferson Campbell, pages 16-17).

At the time of the D-9 settlement, LUA requested from claimant an accounting of costs. (LUA Ex. 12). Claimant responded to this request by submitting statements. We note in comparing counsels' affidavits there is an apparent disagreement as to what statement(s) were provided to LUA. In any event, LUA, based on claimant's counsel's October 7, 1991 statement, concluded that the costs associated with the D-9 settlement were limited to $826.82. Shortly thereafter, claimant's counsel provided a further accounting of expenses paid and projected in the amount of $25,050.87. (PR Ex. 19). Counsel did not include an explanation for this significant change from the prior "accounting" response. By affidavit, claimant's counsel reduced this amount by $596.50 (a cost solely related to the Navistar litigation) for total expenses of $24,454.37. Moreover, claimant's counsel indicated that this total cost figure, although a "combined" figure, was nonetheless directly related to the D-9 claim. Finally, counsel emphasized in his affidavit the great difficulty in attempting to identify costs solely related to the D-9 claim. (Affidavit of G. Jefferson Campbell, pages 16-17).

Although claimant has produced extensive documentation of expenses, these have reflected "combined" costs. We note that it is claimant's primary contention that it was impossible to segregate D-9 costs from Navistar costs as requested by LUA. Nonetheless, given the voluminous record, and the fact that the "cost" information was fully within claimant's counsel's control, we are not persuaded that the task of segregating costs out was unachievable. See Thomas Lund, supra at 1356-57. Accordingly, based on this record, we find that claimant has failed to prove her entitlement to reimbursement for costs related to the D-9 settlement exceeding the amount of $826.62.

Navistar Judgment

As previously discussed, claimant seeks a combined cost in the amount of $56,371.14 based on statements and accountings of all litigation expenses. (LUA Ex. 20). LUA disputes this figure, arguing that claimant is entitled to no more than $7,429.49 of "different kinds" of litigation expenses other than what was previously submitted and considered by the trial court. LUA would include in the $7,429.49 figure costs associated with claimant's counsel's travel, phone, copying, postage and Federal express

deliveries. LUA would exclude from this figure costs associated with trial witness fees and mileage, deposition testimony fees and costs, cost of public records, books and documents, service fees or trial subpoenas, and the other miscellaneous items. (LUA's petition, page 7; see also LUA Exs. 19, 20; PR Ex. 36).

In particular, LUA disputes the following costs:

(1) A $174.95 expert fee for the services of stockbroker, Scott Davidson. (LUA Ex. 20-49). LUA argued that this amount was already compensated for as part of the attorney fee.

(2) A $3,865.47 expert fee for the biomechanical systems analysis provided by Talbott Associates, Inc. (Barry Bates, Ph.d). The cost was denied on the basis that there was no itemization and that the billing was duplicative. (LUA Ex. 20-52).

(3) A $1,095.10 attorney fee for claimant's co-counsel. The cost was denied because allegedly it was an attorney fee not a cost. (LUA Ex. 20-46).

(4) Costs of $826.82. This cost was denied on the basis that it should be recovered from the D-9 settlement proceeds. (LUA Ex. 20-12-14).

(5) A $16,764.27 investigative report from Accident and Failure Investigations, Inc. (Michael York). (LUA Ex. 20-47-48). This cost was rejected by LUA because it was a rebilling, and further, because it was not a reasonably necessary cost. Further, LUA argues that even assuming the cost was reasonably necessary the amount charged is excessive. LUA offers an alternative figure of $9,535.71 (eliminating witness fees). Moreover, LUA argues that the fee should be limited further yet to the amount charged for York's prior investigative report in the amount of $3,877.33. (LUA's petition, pages 8-9).

Here, costs were itemized and submitted to the trial judge for consideration in the amount of $13,396.02. Navistar objected to the amount and a hearing was held. Thereafter, the trial court, based on ORCP 68, awarded claimant court costs in the amount of $7,677.99. LUA contends that claimant had an opportunity to present and have considered costs associated with the Navistar litigation, and thus, is bound by the trial court's decision. Therefore, LUA argues that expenses that were before the trial court, but were not allowed, cannot be recouped before the Board as litigation expenses.

We agree with LUA to the extent that those costs awarded by the trial court can not be rebilled as litigation expenses. To do so would be to compensate claimant twice. However, we do not agree that expenses considered by the trial court, but rejected, cannot be considered litigation expenses.

We have previously considered this matter in Thomas Lund, supra. In that case, the issue was whether or not the claimant's recovery of costs was limited to only those costs the claimant recovered in the trial court. We began by noting a distinction between "court costs" and "litigation expenses." We reasoned that to find court costs and litigation expenses to be one and the same would effectively eviscerate the intent behind ORS 656.593(1)(a) and would, since the claimant is generally contractually bound for the balance of litigation costs, have the practical effect of reducing the claimant's statutory share.

Accordingly, we held that the claimant's reimbursable costs incurred during the litigation of a third party action are not limited to court costs. In this regard, we did not consider court costs to be the same as litigation expenses. We held that the claimant is entitled to reimbursement from the third party recovery for previously unreimbursed costs which are reasonably and necessarily incurred during the litigation of the third party action. Accordingly, relying on the Lund case, we consider all costs not previously awarded by the trial court regardless of whether or not claimant had previously petitioned and was refused these costs.

After reviewing the record, we find the documentation adequate to find that the litigation expenses recorded therein represents unreimbursed costs, not previously awarded as court costs, which were reasonably and necessarily incurred during the Navistar litigation. (LUA Ex. 19, 20; PR Ex. 36).

We include in this assessment the $174.95 expert fee paid to Scott Davidson. Our review indicates that this fee was incurred as a reasonable litigation expense. We find no evidence that it was previously included in counsel's attorney fee. (See LUA-Ex. 20-49; Supplemental Affidavit of G. Jefferson Campbell, pages 1-2).

We also include the billing of $3,865.47 from Talbott Associates, Inc. It is not necessary for billings to be itemized in order to be reimbursed. It is sufficient that the billings indicate what they are for and who is to be paid. With respect to alleged rebilling, we are not persuaded that claimant had been previously reimbursed by the trial court for this charge. (PR Ex. 36, LUA Ex. 20-4). Therefore, claimant is entitled to this cost as well.

With respect to the $1,095.10 cost for claimant's co-counsel we find this cost is not an attorney fee, but rather costs. This conclusion is based upon on our review of LUA Exhibit 20-46, as well as counsel's statement that the $1,095.10 invoice is a statement of expenses incurred by claimant's co-counsel. (See LUA Ex. 20-46; Supplemental Affidavit of G. Jefferson Campbell, pages 1-2). Therefore, the cost is reimbursable.

After considering the arguments of counsel as well as Mr. York's affidavit, we conclude that the fee for Accident and Failure Investigations, Inc. is a reasonable and necessary litigation expense. Indeed, it was this report which indicated that the cause of the accident was not speed (prior reports had suggested otherwise). Accordingly, the report was instrumental in claimant's prevailing in the Navistar litigation. (Affidavit of Michael York; LUA Ex. 20-47-48).

However, we do exclude $826.82 from claimant's proposed distribution for costs. Inasmuch as we have already attributed the cost amount of $826.82 to the D-9 Construction claim, that amount is properly excluded.

To conclude, we find litigation expenses, not already compensated for by the trial court, amount to a total of $55,544.32.

Claimant's Costs

In addition, claimant seeks costs for claimant's lost wages and travel expenses during the course of the trial in the amount of $1,827.50. (Claimant's reply brief, pages 7-8; Affidavit of G. Jefferson Campbell, page 8). In Thomas Lund, supra, we held that claimant is entitled to reimbursement from the third party recovery for previously unreimbursed costs which were reasonably and necessarily incurred during the litigation of the third party action.

We note, however, this issue was not raised until the claimant's cross-reply brief. We, therefore, conclude it would be fundamentally unfair to consider this request at this late stage of the proceedings. In any event, we consider claimant's counsel's affidavit to be insufficient to establish claimant's alleged lost wages and travel expenses resulting from the trial. Finally, because already approved litigation expenses far exceed claimant's third party judgment gross recovery, there are no proceeds remaining for such reimbursement for claimant's personal litigation costs.

Extraordinary Attorney Fees

As previously noted, attorney fees in no event shall exceed the advisory schedule of fees established by the Board for third party actions. ORS 656.593(1)(a); Shipley v. SAIF, 79 Or App 149, 152-153 (1986). The Board's rule concerning attorney fees in third party cases is set forth in OAR 438-15-095:

> "Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33 1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 and 656.595 is authorized."

Extraordinary attorney fees have been allowed in the past. In Leonard F. Kisor, 35 Van Natta 282 (1983) a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee. In John Galanopoulos, 35 Van Natta 548 (1983) an extraordinary fee of 40 percent was allowed where claimant's attorney expended nearly three full months in trial preparation for a five day trial and achieved an extremely favorable result. In John P. Christensen, 38 Van Natta 613 (1986) claimant's counsel was awarded 50 percent of proceeds where the case had been litigated over a 10-year period, including two appearances before the Oregon Supreme Court and the paying agency did not object.

Claimant's counsel is requesting an extraordinary attorney fee of 40 percent of the third party recovery. Claimant bases this request on two factors: (1) the existence of extraordinary circumstances justifying such an attorney fee pursuant to OAR 438-15-095; and (2) authority to award such a fee, regardless of the circumstances, pursuant to claimant's executed retainer agreement and an order of the probate court approving the retainer agreement. (PR Exs. 3, 4). LUA opposes claimant's counsel's request for an extraordinary fee.

Attorney fees in third party matters are confined to 33 1/3 percent of the gross recovery. Awarding extraordinary fees in excess of this percentage is the special statutory province of the Board upon a finding of extraordinary circumstances. ORS 656.593(1)(a); OAR 438-15-095. That finding is conclusive of the matter notwithstanding an executed retainer agreement that says otherwise. Moreover, we do not find the Judge's order allowing special counsel to be retained to also "approve" explicitly or implicitly the contingency fee arrangement. Even assuming such an interpretation can be drawn from the Judge's order, such an order would not be statutorily binding absent authorization from the Board.

We therefore consider whether or not extraordinary circumstances exist to warrant an extraordinary attorney fee. There is no evidence of extraordinary circumstances that would justify an extraordinary fee for counsel's efforts in procuring the D-9 settlement. With regard to the Navistar litigation, we recognize counsel has expended significant efforts in preparing and presenting claimant's case. However, in light of the outcome, we can not conclude that counsel is entitled to an extraordinary fee. Compare with John P. Christensen, supra; John Galanopoulos, supra; Leonard F. Kisor, supra.

Accordingly, for the reasons expressed herein, claimant's attorney is not entitled to an extraordinary attorney fee equal to 40 percent of either the D-9 settlement proceeds or the Navistar litigation proceeds. Rather, claimant's attorney shall receive 33 1/3 percent of the D-9 settlement proceeds as prescribed in OAR 438-15-095. In addition, claimant's attorney shall receive 33 1/3 percent of the Navistar judgment proceeds as prescribed in OAR 438-15-095. See Lela Nyseth, 42 Van Natta 2057 (1990); David S. Holcomb, 41 Van Natta 195 (1989).

Attorney Fees for Filing a Third Party Petition

Claimant seeks an award of attorney fees for her counsel's efforts in filing the third party petition. Claimant argues two separate bases for an award.

Claimant seeks an award of attorney fees pursuant to ORS 656.382(1) for LUA's alleged unreasonable resistance to the payment of compensation. We have previously held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. See Theresa J. Lester, 43 Van Natta 338 (1991); Arlo W. Dunbar, 40 Van Natta 366, 491 (1988); Raymond Steiner, 40 Van Natta 381, 382 (1988). In any event, we are persuaded that LUA was acting within its rightful authority as a paying agency under the third party statutes. The request is denied.

Claimant also argues that she is entitled to an attorney fee under the equitable doctrine of "preservation of the common fund" for her efforts in "preserving" from "wrongful distribution" the amounts deposited in a special trust account pending resolution of the third party claim dispute before the Board. Reviewing the cases cited by claimant, we assume such a fee would not be in addition to, but rather would come out of the "common fund," in this case the recovery proceeds.

Although the court has held that principles of equity may be applied in some circumstances in workers' compensation matters, these particular circumstances do not warrant application of equity principles. See Swift & McCormick Metal Processors Association, Inc. v. Durbin, 117 Or App 605 (1993); Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992). As noted above, claimant's entitlement to attorney fees is expressly governed by statute. Thus, we have no authority to "engraft on the statutory scheme" any other basis for award of additional attorney fees from proceeds or for that matter to impose on the paying agency the requirement to pay attorney fees. See Stoval v. Sally Salmon Seafood, 306 Or 25, 38 (1988). Furthermore, since we have concluded that LUA was exercising its lawful right to seek reimbursement of its claim costs, we would not consider it equitable to foreclose LUA from receiving such a recovery or to require LUA to pay an attorney fee to claimant's counsel for responding to LUA's lawful request for reimbursement. Therefore, we find claimant is not entitled to an attorney fee on this basis as well.

Distribution of Proceeds

Based on the foregoing analysis, the distribution schedule shall be as follows:

D-9 Construction

Settlement	$ 15,000.00
Costs	- 826.82
Attorney fee of 1/3	- 5,000.00
Sub-total	$ 9,173.18
Claimant's 1/3 share	- 3,057.73
Remaining Balance to LUA	$ 6,115.45

Accordingly, claimant's counsel is directed to distribute the proceeds of the third party settlement in the manner detailed above, which we hold to be a "just and proper" distribution. ORS 656.593(3). Inasmuch as LUA's claim costs far exceeds the balance of the recovery after claimant's statutory 1/3 share is deducted, no further balance remains for claimant.

Navistar

Judgment	$ 42,343.64
Attorney fee of 1/3	- 14,114.55
Litigation expenses	- 55,544.32
Remaining Balance	$(27,315.23)

Accordingly, claimant's counsel is directed to distribute the proceeds of the third party judgment in the manner set forth in ORS 656.593(1). Inasmuch as attorney fees and litigation expenses far exceed the gross recovery, there are no proceeds remaining for claimant's 1/3 statutory share or for reimbursement of LUA's lien.

IT IS SO ORDERED.

February 10, 1994 Cite as 46 Van Natta 233 (1994)

In the Matter of the Compensation of
NATHANIEL P. BAKER, Claimant
WCB Case No. 93-00115
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed en banc.

The insurer requests review of those portions of Referee McWilliams' order which: (1) denied its motion to dismiss for lack of jurisdiction; and (2) increased the rate of claimant's temporary disability compensation. On review, the issues are jurisdiction and rate of temporary disability.

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

Claimant, a truck driver, sustained an accepted work injury in 1991. At the time of the injury, claimant was paid at the rate of 18¢ per mile. The employer characterized claimant's compensation as 13¢ per mile "wages" and 5¢ per mile "subsistence." (Ex. 9). The insurer paid temporary disability benefits calculated on the basis of wages of 13¢ per mile.

Claimant requested a hearing, contending that his temporary disability benefits should be based on wages of 18¢ per mile, pursuant to the employment contract he signed at the time of hire in April 1989. That contract provided, in pertinent part, that "[u]pon employment all drivers will receive seventeen cents (.17¢) [sic] per mile for all dispatched miles traveled." (Ex. 2).

At hearing, the insurer moved to dismiss claimant's hearing request, contending that the Hearings Division lacked jurisdiction over a dispute concerning the proper rate of temporary disability, where the administrative remedy set forth in the Director's rule, OAR 436-60-025, had not been exhausted.

The Referee denied the motion to dismiss, reasoning that the Director's rule could not divest the Hearings Division of jurisdiction over claimant's hearing request when the insurer failed to seek an administrative remedy. On the merits of claimant's hearing request, the Referee held that claimant's wage was established by the explicit terms of his employment contract. Therefore, the Referee concluded that claimant's rate of temporary disability should be based on a wage of 18¢ per mile.

Regarding the jurisdiction issue, we agree with the Referee that the Hearings Division had jurisdiction over claimant's hearing request, even though neither party first sought a determination by Compliance of the correct rate of temporary disability under OAR 436-60-025(5). We supplement the Referee's analysis with the following reasoning.

The parties apparently agree that claimant's temporary disability rate should be determined under ORS 656.210(2)(c), which provides, in part:

> "For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the workers' weekly wage."

In response to this statutory directive, the Director has promulgated OAR 436-60-025, subsection (5) of which provides, in part:

> "The insurer shall resolve situations not covered by ORS 656.210 or this section by contacting the employer and worker to determine a reasonable wage. If an agreement cannot be reached, the dispute shall be referred to Compliance for resolution." (Emphasis added).

Here, neither party asked Compliance to resolve the wage dispute. Relying on the portion of the rule emphasized above, the insurer contends that the Hearings Division lacked jurisdiction because the dispute over a "reasonable wage" was not first referred to Compliance. In other words, the insurer contends that the Director has exclusive, original jurisdiction over "reasonable wage" disputes, pursuant to the above-cited rule. We disagree.

ORS 656.283(1) provides, in relevant part, that "any party or the director may at any time request a hearing on any question concerning a claim." ORS 656.704(3) defines the phrase "concerning a claim," and sets forth the respective authority of the Director and the Board (and its Hearings Division) to conduct hearings, investigations and other proceedings under Chapter 656. That statute provides, in relevant part:

> "[M]atters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter."

The dispute over the rate of claimant's temporary disability is a "matter concerning a claim," since the amount of claimant's compensation is directly in issue. This dispute is not within the exception for resolving medical disputes cited in ORS 656.704(3), nor is it subject to any other statutory directive conferring exclusive or original jurisdiction on the Director. Compare, e.g., ORS 656.262(10)(a); 656.268(4)(e) and (5); 656.327.

Furthermore, we find that ORS 656.210(2)(c) does not confer exclusive or original jurisdiction on the Director to resolve "reasonable wage" disputes, since that statute provides only that "the director, by rule, may prescribe methods for establishing the worker's weekly wage." In other words, the statutory language is permissive, not mandatory. Moreover, the statute pertains to prescribing methods for determining a worker's weekly wage for the purpose of calculating temporary disability benefits. The statute does not designate the Director as the original tribunal for resolving such disputes.

Administrative rules must be consistent with an agency's statutory authority. An agency may not alter, 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). Although one of the Director's rules promulgated pursuant to ORS 656.210(2)(c) provides that, under certain circumstances, a "reasonable wage" dispute shall be referred to Compliance for resolution, we decline to interpret this rule in such a way as to limit or restrict the Board's jurisdiction over a "reasonable wage" issue. To do so would limit the Board's jurisdiction to hear "any question concerning a claim," which would be contrary to statutory directive.

A party may elect to submit such a dispute to the Director for resolution pursuant to OAR 436-60-025, and the Director may choose to resolve the dispute. Nevertheless, a party's failure to choose such a procedure does not preclude that party from requesting a hearing pursuant to ORS 656.283(1) to seek resolution of this question concerning a claim. Accordingly, we conclude that the Board and its Hearings Division have jurisdiction over this matter.

Regarding the merits of the appropriate rate of temporary disability, we affirm and adopt the Referee's order which concluded that the issue of claimant's wage is controlled by the explicit terms of the contract of hire. See ORS 656.005(27); Dale J. Lindamood, 44 Van Natta 1112 (1992).

ORS 656.005(27) defines "wages" as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent *** or similar advantage received from the employer ***."

Here, claimant's contract of hire expressly provided that all drivers would be paid 17¢ per mile (subsequently increased to 18¢ per mile). The contract is silent regarding any distinction between "subsistence" pay and "wages," nor does it contain any provision for accounting for or deducting a driver's expenses. (See Ex. 2; Tr. 31). Although claimant's check stub separately identified compensation for "subsistence," we find that the employer's accounting method constitutes neither a wage agreement with claimant nor a modification of the written contract. (See Ex. 7). The express terms of the employment contract are clear and unambiguous regarding the amount of claimant's compensation. Therefore, it is unnecessary to resort to extrinsic evidence to determine the parties' agreement. Accordingly, we conclude that claimant's wage at the time of injury was 18¢ per mile, without deduction for expenses.

Our conclusion in this case is consistent with the analysis in Edward J. Connor, 42 Van Natta 917 (1990), in which we held that absent proof of an express or implied agreement providing for the payment of expenses out of remuneration, the carrier was not entitled to deduct expenses from the claimant's remuneration in arriving at his average weekly wage rate. In Connor, the worker, a truck driver, was paid pursuant to a contract which provided that the employer took 10 percent off the top of the worker's gross receipts and paid certain expenses out of the remaining 90 percent. The worker received a check for the balance. The carrier contended that because a portion of the compensation the claimant received in his check was for expenses, it was entitled to deduct that amount from the claimant's remuneration for the purpose of calculating his rate of temporary disability. The Board disallowed any deduction for expenses, holding that the carrier failed to prove the existence of an agreement whereby a specific portion of the claimant's remuneration was intended for reimbursement of expenses.

Here, too, we find that the insurer failed to establish the existence of an agreement between the parties that a portion of claimant's wage is for reimbursement of expenses. Rather, the employment contract that claimant signed expressly provided that his remuneration would be 17¢ per mile, without any deduction for expenses. Accordingly, we affirm the Referee's order finding that claimant's temporary disability rate should be calculated based on a wage of 18¢ per mile.

Inasmuch as we did not disallow or reduce the compensation awarded, 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 rate of temporary 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 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 June 15, 1993 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

February 10, 1994 Cite as 46 Van Natta 236 (1994)

In the Matter of the Compensation of
EDWIN L. EVANS, Claimant
WCB Case No. C4-00085
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, Bruun, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Member Hall and Haynes.

On January 10, 1994, 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.

On January 13, 1994, we requested an addendum to correct the proposed attorney fee of $6,600 or to provide extraordinary circumstances to justify the fee. See OAR 438-15-052. On January 19, 1994, we received the parties' addendum, changing the attorney fee to $6,535, thereby increasing the total due claimant to $40,065.

We have previously concluded that, where the claimant's actual monetary recovery has been increased, due to a proportionate decrease in his counsel's attorney fee, the total consideration for the CDA remains the same. See Richard R. Millus, 45 Van Natta 758, on recon 45 Van Natta 810 (1993). Consequently, we find that the parties' changes to the CDA represent merely a "re-distribution" of funds. Millus, supra.

Therefore, upon review of the document as a whole, we find that it is the intent of the parties to settle this matter for a total consideration of $46,600, with an attorney fee of $6,535 to claimant's attorney and total due claimant of $40,065.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of the amended agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDON E. LEWIS, Claimant
WCB Case No. 92-10488
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of that portion of Referee Nichols' order that set aside its denial of claimant's aggravation claim for a left shoulder condition. Claimant cross-requests review of that portion of the order that awarded an assessed attorney fee of $2,000 for services at hearing. On review, the issues are aggravation and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant has a left shoulder condition for which a claim was accepted and closed. The claim was later reopened and again closed by Notice of Closure on January 28, 1992 with awards of temporary disability benefits and 10 percent unscheduled permanent disability benefits. Claimant was found to be medically stationary as of December 6, 1991, as determined by his treating physician, Dr. Watrous, during claimant's closing examination..

In April 1992, claimant filed a request for reconsideration, challenging the permanent disability award. The December 6, 1991 medically stationary date was not contested (no party suggested that the claim was prematurely closed or that claimant was not medically stationary as of December 6, 1991). Shortly after his April 1992 reconsideration request, claimant returned to Dr. Watrous, complaining of increased symptoms in his left shoulder. On June 6, 1992, claimant was examined by a medical arbiter, Dr. Smith.

On June 17, 1992, an Order on Reconsideration issued awarding 18 percent unscheduled permanent disability. Claimant's temporary disability award, including his medically stationary date, was unchanged. The reconsideration order has not been appealed and has become final by operation of law. See ORS 656.268(6)(b).

In August 1992, claimant filed the aggravation claim at issue in this proceeding. He contended that his compensable condition had worsened since his last award or arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's conclusions and reasoning with the following supplementation.

After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. ORS 656.273(1). In order to determine whether a worker's compensable condition has worsened, it is first necessary to decide what constitutes the worker's last award or arrangement of compensation. In other words, what will be the benchmark or baseline against which the allegedly worsened condition will be compared to determine if an aggravation has, in fact, occurred?

When a claim is closed, the Notice of Closure or Determination Order determines the worker's entitlement to both: (1) temporary disability benefits extending through the date claimant's compensable condition becomes medically stationary; and (2) permanent disability benefits. See generally ORS 656.268. Only evidence generated up through the date of closure is considered in determining his entitlement to such benefits.

If the Notice of Closure or Determination Order is not appealed, the worker's entitlement to temporary disability and permanent disability benefits is finally determined as of the date of closure based on claimant's medically stationary condition. Thus, if the alleged worsening occurred following the Notice of Closure or Determination Order, such orders constitute the "last award or arrangement of compensation" within the meaning of ORS 656.273(1). In order for the worker to obtain additional temporary disability or permanent disability benefits, he must prove that his condition has worsened since the date of claim closure when his condition was medically stationary.

If, however, the Notice of Closure or Determination Order has been appealed and claimant is contending that his compensable condition has worsened, the "last award or arrangement of compensation" is more difficult to identify. Prior to the 1990 Act, the solution to this dilemma seemed fairly straight-forward. Despite multiple levels of litigation, the extent of a worker's permanent disability was evaluated at the time of hearing. Thus, in Joseph R. Klinsky, 35 Van Natta 332 (1983), as a matter of policy, the Board interpreted the phrase "last award or arrangement" to mean the date of the worker's last opportunity to present evidence concerning the extent of permanent disability. The Board recognized that that date would generally be the date of the prior "extent" hearing. Hence, if an aggravation claim was subsequently filed, the worker had the burden of proving his condition had worsened since the date of the "extent" hearing.

In 1990, however, the legislature made significant changes to the process by which extent of permanent disability is determined. The most notable change was instituting the mandatory reconsideration process. ORS 656.268(4)(e) and (5). Parties objecting to a Notice of Closure or Determination Order are now required first to request reconsideration by the Department. Id. After reconsideration is completed, a party may then request a hearing on the Department's Order on Reconsideration. ORS 656.268(6)(b).

Despite these changes, the Board has continued to use the date of a worker's last opportunity to present evidence concerning the condition as the "last award or arrangement of compensation." E.g., Grace M. Nyburg, 44 Van Natta 1875 (1992); Frank L. Stevens, 44 Van Natta 60 (1992); Larry H. Erbs, 42 Van Natta 98 (1990). While this approach apparently has been used successfully in those cases, the application of it to all cases under the current law is problematic for the following reasons.

The reconsideration process creates a number of different dates which could arguably constitute a worker's last opportunity to present evidence concerning the extent of his permanent disability. While evidence of a worker's disability is still "presented" at hearing, referees and the Board are now directed to evaluate a worker's permanent disability as of the date of the Department's Order on Reconsideration. ORS 656.283(7), 656.295(5); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Consequently, it could be argued that the hearing is still the last opportunity to present evidence, even though the evidence must relate back to the date of the Order on Reconsideration. It could also be argued that, because all evidence presented at hearing must relate to the worker's condition as of the date of the Order on Reconsideration, that date is actually the worker's last opportunity to present evidence concerning his permanent disability.

The determination of a worker's "last opportunity" is further complicated when a medical arbiter has been appointed to examine the worker under ORS 656.268(7), because that provision does not allow the admission of any subsequent medical evidence of the worker's impairment. Under those circumstances, therefore, it could be argued that the last opportunity to present evidence is the date of the medical arbiter's examination.[1]

Inasmuch as the reconsideration process creates a number of different dates that could be construed as the worker's "last opportunity to present evidence" concerning extent of disability, we believe this phrase is ill-suited for conducting an "aggravation" analysis under the current statutory scheme. Although not articulated in such terms, our holding in Stevens and its progeny were premised on the statutory presumption that claimant's condition was medically stationary on the date of his last award or arrangement of compensation. In other words, had claimant's condition not been medically stationary, the last award or arrangement of compensation would not have issued because it would have been inappropriate to evaluate the extent of claimant's disability. See ORS 656.268(4)(a).

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[1] A worker's "last opportunity" can also depend on whether the worker appeals the Department's Order on Reconsideration. On reconsideration, the Department's review is generally limited to evidence considered at claim closure; beyond that, the Department may consider corrective information or "medical evidence that should have been but was not submitted by . . . the attending physician at the time of claim closure." ORS 656.268(5). Thus, if the Order on Reconsideration is not appealed, it could be argued that claimant's last opportunity to present evidence concerning extent of disability was the date of claim closure. On the other hand, if the Department appointed a medical arbiter to examine claimant, and the arbiter's examination report was considered on reconsideration, it could also be argued that the date of the medical arbiter's examination was the worker's last opportunity to present evidence concerning extent of disability.

Although each of the above-referenced "opportunities" would carry different dates and be based upon separate evaluations, the common denominator for purposes of an "aggravation" analysis would be whether they addressed a medically stationary condition. Thus, when a claimant contends that the compensable condition has worsened since the last award or arrangement of compensation, the analysis must start with locating the date claimant was last determined, medically and legally, to be medically stationary. For purposes of ORS 656.273(1), a person's medically stationary determination (date) is the defining centerpiece to the "last award or arrangement of compensation" from which the person's "worsened" (i.e., no longer medically stationary) condition will be evaluated.

Whether the aggravation claim is asserted after a Notice of Closure or Determination Order has become final by operation of law or during the reconsideration appeal process, or after the ultimate appealable order has become final, the "base line" for determining whether the compensable condition has worsened is the evidence describing the claimant's "medically stationary" condition at or before the last award or arrangement of compensation (i.e., the last time the claimant was medically and legally determined to be medically stationary). As with any evidence, the degree of probative value attached to a particular report (be that testimonial or documentary) would be determined on a "case-by-case" basis considering (among other reasons) such factors as the physician's familiarity with claimant's condition and the proximity of the "medically stationary" examination/report to the date of the last award or arrangement of compensation. Such evidence would necessarily include that which is required under ORS 656.273(1) through (8), including objective findings establishing that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award.

The aforementioned approach is not only in accordance with the statutory requirement to evaluate an aggravation claim based on a worsening from the "last arrangement or award of compensation," but it is a practical approach that is easy to understand and apply. Moreover, this approach is predictable, legally and medically sound and eliminates the gamesmanship that can possibly occur in a system based on "the last opportunity to present evidence" standard.

As noted above, we consider our approach to be consistent with the statutory scheme. The closure order determines a worker's entitlement to temporary benefits through the date of claim closure, including a determination of claimant's medically stationary date. It does not determine the worker's entitlement to temporary disability benefits for any period after the closure date. Thus, if the closure order is appealed (but is not subsequently set aside as premature), any subsequent determination of the worker's entitlement to temporary disability benefits under that closure order is limited to the period preceding the closure date. Additional temporary disability benefits beyond the closure date could only be obtained if the worker establishes a worsening of his compensable condition since the closure order. See ORS 656.273(1).

A worker's entitlement to permanent disability benefits is similarly tied to claim closure resulting from his "medically stationary" status. A claim may not be closed unless the worker's condition is medically stationary, i.e., no further material improvement is reasonably expected. See ORS 656.268(1), 656.005(17). Thus, if the worker's claim has been properly closed, his condition has presumably stabilized and can therefore be evaluated for any permanent disability.

We recognize that the extent of the worker's permanent disability may be evaluated on different dates, depending on the subsequent course of litigation (e.g., date of closure, date of the medical arbiter's examination, or date of reconsideration order). However, as previously discussed, the statutory scheme is based on the presumption that the worker's condition remains "medically stationary" throughout the process; i.e., the worker's permanent disability, if any, remains stable from the closure date through the subsequent "extent" litigation.

Further, in those claims where the worker's condition does not remain medically stationary through the reconsideration process, there are procedural safeguards in place to ensure that the worker's permanent disability is rated at a medically stationary level. If, for example, a worker requests reconsideration, including a medical arbiter's examination, and subsequently becomes non-medically stationary, the Department rules provide that the arbiter should not perform an examination. OAR 436-30-050(11)(d). Rather, the arbiter performs a record review, and the Department's impairment rating is based on the arbiter's opinion regarding impairment at the time of claim closure. Id. Thus, the worker's permanent disability is rated on the basis of his medically stationary condition at the time of claim closure. Such a procedure would also permit a worker to file an aggravation claim seeking to

establish that his compensable condition worsened since the Notice of Closure or Determination Order (the last award or arrangement of compensation).

Inasmuch as a worker's entitlement to both temporary disability and permanent disability benefits on a closed claim is tied to the worker's "medically stationary" condition, we conclude that evidence regarding that "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). As previously discussed, this approach gives the parties a legally and medically predictable date with which to work and eliminates possible gamesmanship under a "last opportunity to present evidence" approach.

Furthermore, this approach protects the worker's right to prove his entitlement to temporary disability benefits for any period after the closure date, even though he may be litigating the extent of his permanent disability through various levels of appeal. That is, a worker who suffers a temporarily disabling worsening of his condition after the closure date will not be precluded from proving an aggravation and, hence, establishing his entitlement to additional temporary disability benefits.[2]

We now apply the aforementioned analysis to the present case. A January 28, 1992 Notice of Closure closed claimant's left shoulder claim with a 10 percent unscheduled permanent disability award. The award was based on clavicle and acromion surgery. Claimant was determined to be medically stationary as of December 6, 1991, the date of Dr. Watrous' closing examination. Reporting that claimant had returned to his regular job patching doors, Dr. Watrous recommended that claimant permanently refrain from turning heavy doors until he was provided with suitable equipment to assist him.

In April 1992, claimant requested reconsideration of the Notice of Closure. He contested his impairment findings, as well as the rating of his impairment and his "age, education, and adaptability" factors.

On April 15, 1992, claimant returned to Dr. Watrous complaining of intermittent left shoulder pain. Recommending that claimant continue his "same modified duty," Dr. Watrous scheduled a re-examination for May 11, 1992. After May 11 and May 22 re-examinations, Dr. Watrous reported that claimant was not able to tolerate the repetitive strenuous arm activities necessary in mill work. Consequently, Dr. Watrous recommended alternative employment counseling.

On June 6, 1992, a medical arbiter examination was conducted by Dr. Smith. Describing claimant's limited range of motion findings as subjective in nature, Dr. Smith concluded that claimant's current lifting ability was around 10 pounds (but was expected to increase to 30 to 40 pounds).

On June 12, 1992, claimant sought emergency room treatment for increasing left shoulder pain. He attributed his complaints to performing more lifting duties as an off bearer. On June 15, 1992, Dr. Watrous reported that claimant remained released to work, but was subject to a 10 pound lifting limit with no arm use over the shoulder level. Dr. Watrous repeated his prior recommendation for vocational assistance.

On June 17, 1992, an Order on Reconsideration issued. Although finding claimant's permanent impairment to be the same as found by the Notice of Closure (10 percent), the reconsideration order found claimant to be entitled to education / skill (3), SVP (1), and adaptability (2) values. Consequently, the reconsideration order increased claimant's unscheduled permanent disability award from 10 percent to 18 percent.

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[2] Upon closure of the aggravation claim, or if the worker is seeking additional permanent disability benefits only, see Stepp v. SAIF, 304 Or 375 (1987), any prior awards of permanent disability are considered in determining entitlement to permanent disability benefits. Thus, when claimant's aggravation claim is eventually closed, the Order on Reconsideration award of 18 percent unscheduled permanent disability will be considered in determining whether claimant has proved entitlement to additional permanent disability benefits.

On June 22, 1992, claimant returned to Dr. Watrous. Inasmuch as his employer did not have employment within claimant's limitations, Dr. Watrous reported that claimant had been on "full disability." Noting that he was holding claimant off work until suitable accommodations at work, job site changes, or plans for retraining were made, Dr. Watrous issued a "Medical Status Report," opining that claimant was "unable to return to work."

On July 6, 1992, Dr. Watrous concluded that claimant had sustained a material worsening of his left shoulder condition resulting from his attempt to return to work. Reporting that claimant was not able to use his arms for any form of strenuous or repetitive labor, Dr. Watrous repeated that claimant was unable to return to work.

On August 5, 1992, the employer acknowledged receipt of claimant's counsel's July 24, 1992 letter (including Dr. Watrous' letter) alleging an aggravation of claimant's compensable left shoulder condition. Asserting that the submitted information did not meet the criteria of ORS 656.273, the employer denied the aggravation claim.

On October 9, 1992, Dr. Watrous responded to several questions posed by claimant's counsel. Dr. Watrous agreed with the statement that he had taken claimant off work on July 6, 1992 based on a conclusion that there had been a worsening of claimant's underlying condition which totally disabled him from working in a mill environment with repetitive lifting and moving work laterally with his arms.

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since his last award or arrangement 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, rev den 312 Or 150 (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, if such was contemplated by the previous permanent disability award. See ORS 656.273(8).

Although claimant actually filed his aggravation claim after the June 17, 1992 Order on Reconsideration, he contends that his compensable condition worsened on June 12, 1992 (following the performance of his "off bearer" duties). Specifically, claimant asserts that this incident triggered Dr. Watrous's 10 pound lifting capacity restriction and, when no such light duty position was available, resulted in Dr. Watrous' July 6, 1992 total work restriction.

Since claimant is asserting a "pre-reconsideration order" worsening, he must establish that his compensable condition has worsened since the January 28, 1992 Notice of Closure (the last award or arrangement of compensation prior to the alleged worsening).[3] Our review of the record confirms claimant's contention.

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[3] Claimant's theory could also be interpreted as a contention that his alleged worsening arose subsequent to the Order on Reconsideration. Such alternative theories would be permissible. Of course, the analysis would be modified because the last award or arrangement would be the Order on Reconsideration, rather than the Notice of Closure. Inasmuch as we have agreed with claimant's argument that his compensable condition worsened after the Notice of Closure but before the reconsideration order, it is unnecessary to address this alternative aggravation theory.

Nevertheless, had we engaged in such an analysis, we would find that Dr. Watrous' July 6, 1992 and October 9, 1992 opinions support a conclusion that claimant's compensable condition worsened since the June 17, 1992 Order on Reconsideration. Moreover, since the record does not establish that the reconsideration order contemplated waxing and waning of symptoms (because the impairment value was based on a clavicle and acromion surgery), it is unnecessary to determine whether claimant's symptoms exceeded those contemplated by the reconsideration order award. Finally, even if the reconsideration order did contemplate such symptoms, Dr. Watrous' conclusions regarding claimant's inability to continue performing repetitive and strenuous arm activities establish that the symptoms exceed any fluctuating symptoms previously contemplated.

Dr. Watrous reported that claimant's left shoulder condition had sustained a material worsening following his attempt to return to work. Claimant had returned to work (with a no heavy work limitation) following Dr. Watrous' December 6, 1991 "medically stationary" examination. Claimant continued his attempts at working through the June 12, 1992 "off bearer" incident. This incident prompted Dr. Watrous further work modification to a 10 pound lifting limitation with no overhead use of the arms. On July 6, 1992, when no such suitable employment was available, Dr. Watrous determined that claimant was unable to return to work. Dr. Watrous subsequently explained that, based on claimant's material worsening, he had been taken off work because he was unable to use his arms for any strenuous or repetitive activity in a mill environment.

Based on these unrebutted conclusions, we are persuaded that claimant's condition at the time of the January 28, 1992 Notice of Closure (release to regular work subject to a heavy work restriction) had materially worsened following his attempted return to work. This finding is based on Dr. Watrous' June 15, 1992 work modifications, as subsequently supported by his July 6, 1992 "total work restriction" report and his October 9, 1992 "materially worsening" report.

Finally, since the Notice of Closure award was based on claimant's clavicle and acromion surgery, the record does not establish that claimant's prior award contemplated future waxing and waning of symptoms. Therefore, it is unnecessary to determine whether claimant's symptoms exceeded any contemplated fluctuating symptoms. See ORS 656.273(8); Allen G. Hall, 45 Van Natta 2025 (1993). However, even if such symptoms were contemplated, Dr. Watrous' July 6, 1992 and October 9, 1992 opinions establish to our satisfaction that claimant's current symptoms are more than a waxing of waning of contemplated symptoms.

In conclusion, we hold that claimant's compensable left shoulder condition worsened since the January 28, 1992 Notice of Closure. Inasmuch as claimant has carried his burden of proving that his condition had worsened since the last award or arrangement of compensation, we conclude he has established a compensable aggravation.

Attorney Fees

Claimant asserts that the Referee's award of $2,000 for an assessed attorney fee is insufficient. After considering the factors set forth in OAR 438-15-010(4), we find that $2,000 is a reasonable attorney fee. In particular, this conclusion is supported by the time devoted to the case (as represented by the record), the complexity of the issues, and the value of interest involved.

Claimant's attorney is entitled to an assessed attorney fee for services on review regarding the aggravation issue. See ORS 656.382(2). After again 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 $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated December 8, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
NANCY R. CHAPIN, Claimant
WCB Case No. 92-11842
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Referee Livesley's order that increased claimant's unscheduled permanent disability award for a cervical condition from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to 18 percent (57.6 degrees). The employer argues that the Referee erred in excluding a "post-reconsideration" letter from the medical arbiter. (Ex. 8). Claimant contends that, if the medical arbiter's letter is admitted, a physical therapist's "post-reconsideration" letter should also be admitted. (Ex. 7). On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

The Referee excluded proposed Exhibits 7 and 8, a letter from the medical arbiter to the employer's counsel and a letter from claimant's physical therapist to claimant's counsel. Both documents were generated after the Order on Reconsideration issued.

CONCLUSIONS OF LAW AND OPINION

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

The essence of this dispute is whether the cervical range of motion measurements of the physical therapist (adopted by the treating physician) are more persuasive than those of the medical arbiters. We agree with the Referee's reasoning that the therapist's findings (as expressly adopted by claimant's attending physician) are more persuasive. In addition, we note that the therapist's physical capacities evaluation was extensive. (See Ex. 3). Moreover, Dr. Cordes, treating physician, adopted the therapist's findings, stating, "I do believe that these [findings] are indicative of [claimant's] permanent impairment consistent with what was found previously." (Ex. 5).

On this evidence, we agree with the Referee that the physical therapist's measurements (which were adopted by the attending physician) reliably represent claimant's permanent impairment. See OAR 436-35-007(8); Dennis E. Connor, 43 Van Natta 2799 (1991); see also Driver v. Rod & Reel Restaurant, 125 Or App 661 (1994); Alex J. Como, 44 Van Natta 221 (1992); OAR 436-10-080(5).

Finally, we acknowledge the parties' contentions concerning the admissibility of proposed Exhibits 7 and 8. Those exhibits were excluded, based on the Referee's understanding that medical evidence generated after an Order on Reconsideration is not admissible. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993).

The disputed evidence consists of a November 17, 1992 letter from Dr. Snodgrass, one of the medical arbiters, (Ex. 7), and a December 4, 1992 letter from claimant's physical therapist, (Ex. 8). In his letter, Dr. Snodgrass describes claimant's arbiter evaluation; explains the AMA Guidelines for determining lost range of motion based on inclinometer measurements; and attacks the physical therapist's residual functional capacity evaluation as containing unreliable range of motion findings. In her letter, the physical therapist describes her training in the use of an inclinometer for range of motion evaluations. Both letters refer to prior examinations and neither makes additional or new findings.

We need not resolve these evidentiary rulings because, assuming without deciding that these "post-reconsideration"/ "post-medical arbiter" letters could be considered, we would reach the same conclusion reached by the Referee. In other words, we would continue to rely on the therapist's impairment findings (as adopted by the treating physician) for the reasons stated above. Accordingly, because resolution of the evidentiary dispute would not change the result, we decline to address it.

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 $1,075, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 16, 1992 is affirmed. For services on review, claimant's counsel is awarded a $1,075 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
SANDRA L. DEHART, Claimant
WCB Case No. 92-05934
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scott Terrall, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Nichols' order which set aside its denial of claimant's occupational disease claim for her upper back and neck condition. In its brief, the employer also contends that the Referee erred in continuing an earlier referee's evidentiary rulings which "froze" the record and excluded the employer's Exhibit 60. On review, the issues are evidence and compensability.

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

Evidence

The hearing in this matter, originally scheduled for July 22, 1992, was postponed pending receipt of a medical report from claimant's treating physician, Dr. Bert. By interim evidentiary order, the earlier referee "froze" the record to include only those documents "in existence and disclosed by the date and time scheduled for hearing on July 22, 1992..." The earlier referee also allowed for depositions on medical reports in existence and disclosed by the date and time of the hearing.

Subsequent to the postponement, the employer submitted an August 6, 1992 medical report, marked as Exhibit 60, for inclusion in the record. Claimant's attorney objected because the document was not in existence and had not been disclosed by the date and time of the originally scheduled hearing. The earlier referee excluded the report in a second interim evidentiary order. The employer did not request reconsideration of or otherwise express dissatisfaction with either interim order.

At the hearing on May 26, 1993, the employer challenged the evidentiary rulings, asserting that the record should not have been frozen and that Exhibit 60 should have been admitted. Alternatively, the employer contended that Exhibit 59A, a July 21, 1992 report from Dr. Bert, should not be admitted if Exhibit 60 were excluded. The Referee rejected the employer's contentions and continued the earlier referee's evidentiary rulings.

ORS 656.283(7) provides that a referee is not bound by common law or statutory rules of evidence *** and may conduct a hearing in any manner that will achieve substantial justice. The statute has been interpreted to give referees broad discretion in the admission of evidence. See e.g. Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee's evidentiary rulings for abuse of discretion. Evan I. Lyman, II, 45 Van Natta 2301 (1993); William J. Bos, 44 Van Natta 1691 (1993).

Here, the original hearing was postponed for incomplete case preparation which was not due to lack of diligence. The employer was aware that a medical report was forthcoming from Dr. Bert. This report was in existence at the time of the original hearing and, although claimant's counsel was prepared to submit the report at the scheduled hearing, it was not submitted because the case had been postponed. The employer had arranged for a deposition of Dr. Bert, but cancelled it in favor of generating the August 6, 1992 report of a records review conducted by Dr. Mawk after the date and time of the original hearing.

Given the broad discretion accorded a referee in evidentiary matters, we cannot conclude that the earlier referee abused her discretion in "freezing" the record or that Referee Nichols abused her discretion in continuing the earlier referee's evidentiary rulings to which the employer did not object until the hearing. We find that these actions were a reasonable method of controlling the evidentiary record and ensuring that a prompt and fair resolution of the dispute was accomplished.

Moreover, there was no abuse of discretion in excluding Exhibit 60, the employer's records review report. The employer was given the opportunity to depose Dr. Bert. It did not do so, but instead chose to solicit a records review report that clearly violated the earlier referee's interim order limiting further evidence to reports in existence at the time of the original hearing. There was also no abuse of discretion in admitting Exhibit 59A, Dr. Bert's medical report, when it was clearly in existence at the time of the originally scheduled hearing. The employer was aware that a last-minute report from Dr. Bert was forthcoming and was given the opportunity to cross-examine Dr. Bert.

Further, Dr. Bert's report qualified as claimant's final rebuttal evidence. Such evidence was specifically allowed by the prior referee's evidentiary ruling. As the party bearing the burden of proof, claimant had the right of last presentation of evidence, including rebuttal evidence. See OAR 438-07-023; Robert D. Sloan, 46 Van Natta 87 (1994).

Based on our review of the record, we do not find that the Referee abused her discretion in excluding Exhibit 60 and admitting Exhibit 59A. We, therefore, affirm the Referee's evidentiary rulings.

Compensability

Given our resolution of the evidentiary matters, we review the compensability issue without considering the employer's records review.

The employer contends that, even if Exhibit 60 is not admitted and Dr. Bert's medical report is considered, claimant still cannot satisfy her burden of proving that her occupational disease claim is compensable. We disagree.

The Referee held that, while Dr. Bert may not have been aware of claimant's off-the-job activities, his opinion that claimant's work activities were the major contributing cause of a worsening of her preexisting upper back and neck condition was still persuasive in the absence of evidence that claimant injured herself off-the-job. We agree with the Referee's reasoning in this regard. We also note that there is no contrary evidence in the record. Alternatively, we note that even if we had considered Dr. Mawk's report, the result would still be the same. Dr. Mawk never examined claimant and we find his opinion conclusory and, therefore, unpersuasive. Accordingly, we affirm and adopt the Referee's opinion on the compensability issue.

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 $1,000, 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 the claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 16, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the self-insured employer.

In the Matter of the Compensation of
GARY D. GALLINO, Claimant
WCB Case No. 91-07125
ORDER ON REMAND (REMANDING TO DIRECTOR'S APPELLATE UNIT)
Malagon, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). The court has reversed our prior order, Gary D. Gallino, 44 Van Natta 2506 (1992), which had held that the Board was without authority to remand an Order on Reconsideration to the Director for the adoption of a temporary rule regarding the disability standards (ORS 656.726(3)(f)(C)). Concluding that the Board has authority to review the Director's application of existing standards to address claimant's impairment and that the Board has implicit authority to remand a case to the Director for promulgation of an applicable temporary rule, the court has remanded.

As explained in the court's opinion, at the time of claim closure, no Director's rule existed which pertained to chondromalacia. Thus, claimant, who suffered from grade II chondromalacia, received no award for this condition. Instead, he was granted 5 percent scheduled permanent disability under the SAIF Corporation's Notice of Closure.

Claimant requested reconsideration, contending that his disability had been improperly rated. Specifically, claimant asserted that there was "no rule under the disability rating standards for the condition chondromalacia." (Ex. 14). Without expressly finding that the existing standards adequately addressed claimant's disability, the Director issued an Order on Reconsideration affirming the Notice of Closure. The reconsideration order found that claimant's 5 percent scheduled permanent disability award provided "adequate compensation for claimant's impairment."

Claimant requested a hearing. The Referee affirmed the Order on Reconsideration. On review of the Referee's order, we affirmed. Gary D. Gallino, supra. We determined that we were without authority to consider whether the Director had correctly applied the existing standards to address claimant's disability. In addition, we held that we were not authorized to remand to the Director for promulgation of a temporary rule.

Relying on ORS 656.726(3)(f)(C), the court has reasoned that the Director was required to stay further proceedings and adopt temporary rules "upon a finding that a disability is not addressed by existing standards." Since the Board is authorized under ORS 656.295(5) to review the correctness of the Director's application of the standards, the court has concluded that we have the power to review the Director's application of existing standards to address chondromalacia. Furthermore, because only the Director can grant the relief requested by claimant (the promulgation of a temporary rule), the court has held that, by necessary implication, we are empowered to remand the case to the Director and must do so. Accordingly, the court has reversed and remanded.

As reasoned by the court, in the event that it is found that a worker's disability is not addressed by the standards, the Director is required to stay further proceedings and adopt temporary rules. See ORS 656.726(3)(f)(C). Here, the Director's Order on Reconsideration does not expressly make such a finding. Instead, the order provides that claimant's 5 percent award "is adequate compensation for claimant's impairment." The lack of an express finding regarding whether claimant's disability was addressed by the standards, in conjunction with the Director's "post-order" promulgation of disability standards addressing chondromalacia (OAR 436-35-230(13)), cause us to find that, at the time of the issuance of the Order on Reconsideration, claimant's disability was not addressed by the standards.

Consequently, the Director was required to stay the reconsideration proceedings and promulgate a temporary rule regarding claimant's disability. Likewise, since we are not authorized to adopt such a rule, we are implicitly empowered to remand the case to the Director for promulgation of that rule and, as mandated by the court, must do so.

Therefore, in accordance with the court's directive, we remand this case to the Director for the promulgation of a temporary rule addressing claimant's disability. In reaching this conclusion, we acknowledge that the Director has subsequently adopted a permanent rule addressing chondromalacia. See OAR 436-35-230(13). Moreover, we recognize that we are authorized to apply such a rule on review. See OAR 438-10-010; 436-35-003(2).

Nevertheless, in light of the court's clear directive, we are compelled to remand to the Director upon a finding that, at the time of issuance of an Order on Reconsideration, a disability was not addressed by existing standards and the Director neglected to stay further proceedings and adopt temporary rules. See ORS 656.726(3)(f)(C); Gallino v. Courtesy Pontiac-Buick-GMC, supra. Furthermore, the Director's subsequent adoption of a permanent rule concerning chondromalacia does not necessarily foreclose the Director from finding that this "worker's disability is not addressed by the [existing] standards." See e.g., WCD Admin. Order 93-054. Accordingly, we remand to the Director for further proceedings consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOEL HANSEN, Claimant
WCB Case No. 93-01453
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

EBI Companies requests review of that portion of Referee Neal's order that requires it to reimburse claimant's guardian for claimant's 1988 medical expenses that exceeded $67,530. Claimant cross-requests review of those portions of the Referee's order that declined to award penalties and interest for EBI's failure to reimburse claimant for those medical expenses. In their respondent's and reply briefs, the parties contest claimant's entitlement to an attorney fee award. On review, the issues are interpretation of the parties' settlement agreement, penalties and attorney fees, and interest. We modify in part and affirm in part.

FINDINGS OF FACT

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

EBI did not participate in the drafting of the Circuit Court order that authorized claimant's guardian to settle and compromise claimant's and claimant's wife's pending claims against a third party.

On July 8, 1988, an earlier referee set aside EBI's denial of claimant's medical services claim. (Ex. 11). That decision was affirmed by the Board on April 30, 1990, and by the Court of Appeals on April 10, 1991. (Exs. 17, 16).

CONCLUSIONS OF LAW AND OPINION

INTERPRETATION OF SETTLEMENT AGREEMENT

In 1983, claimant sustained a devastating compensable injury. EBI accepted the claim and provided benefits. Claimant was subsequently granted an award of permanent total disability.

Claimant initiated a lawsuit against a third party. In February 1984, the third party's liability [illegible] which was guaranteed by Mission National

> "effective January 1, 1984, Mission shall arrange for claimant's guardian to receive $5,000 per month for the remainder of claimant's life, compounding annually at the rate of 3%, which money is to be held for the benefit of EBI and used to satisfy EBI's future expenditures for compensation and other costs of the workers' compensation claim up to an amount of $60,000 per year, plus the 3% increment by which this amount will increase annually starting in 1985." (Id).

Section 6 of the agreement provides that EBI agrees to continue paying claimant's workers' compensation benefits as long as they are required by law. (Id).

Thereafter, the Multnomah County Circuit Court entered an order authorizing claimant's guardian to settle and compromise the pending claims by claimant and his wife against the third party. In addition to language tracking that in section 5 of the parties' settlement agreement, the order provides that "in the event that $60,000 per year is not adequate to pay for the expenses of [claimant], then EBI will be required to pay the amount of the reasonably expended costs for all of [claimant's] care over and above $60,000 per year * * *." (Ex. 3a-4 to -5). EBI did not participate in the drafting of the order.

From 1985 through 1987, EBI sought reimbursement for claimant's medical costs. Each year, those costs were less than $60,000. In December 1987, claimant began treating at Timber Ridge Ranch, a more expensive rehabilitation center. (See Ex. 11). EBI denied that the treatment was reasonable and necessary. (See Id). On July 8, 1988, an earlier referee set aside EBI's denial, and remanded the claim to EBI for processing and payment of medical benefits. (Id). This Board and the Court of Appeals affirmed the referee's order. (Exs. 17, 16).

The present controversy arose after claimant's guardian paid approximately $254,470 to Timber Ridge Ranch for claimant's medical care in 1988. (See Ex. 25-1).[1] Claimant's guardian requested reimbursement from EBI of the amount that exceeded $67,350 ($60,000 plus the 3% increase compounded annually beginning in 1985). EBI refused to reimburse claimant's estate for any of the requested amount, because it determined that there should be a balance of over $194,000 in the trust account for the monies that claimant's guardian was to hold for EBI's benefit. (Exs. 24, 27).

On review, EBI argues that, in entering into the settlement agreement, the parties intended to create an income stream to cover all of claimant's anticipated future medical expenses. It further argues that the monies Mission paid to claimant's guardian were to be held in trust indefinitely for the benefit of EBI. Therefore, because the trust account balance should have exceeded the total of claimant's medical expenses in 1988, EBI asserts that it owes claimant nothing.

In response, claimant argues that the Referee correctly concluded that, notwithstanding extrinsic evidence to the contrary, the terms of the settlement agreement, and the Circuit Court order, reveal that the parties intended that EBI be held responsible for all of claimant's medical expenses that exceed $60,000, plus the incremental increase, in any given year. Therefore, claimant argues, EBI should be required to reimburse claimant's guardian for claimant's 1988 medical expenses that exceeded $67,530.

Before we proceed to interpret the parties' settlement agreement, we note that, as the employer's workers' compensation carrier, EBI is, by law, responsible for paying all of claimant's compensable medical expenses. See ORS 656.245. EBI's responsibility is also manifest in the settlement agreement and in the earlier referee order that set aside EBI's denial of the medical treatment that gave rise to the medical expenses at issue in this case. Section 6 of the parties' agreement expressly provides that EBI will continue to pay claimant's workers' compensation benefits as provided by law. (Ex. 3-3). Finally, the referee's order explicitly requires EBI to accept and process claimant's medical services claim in accordance with the law. (Ex. 5).

pay such bills. In any event, the litigation regarding EBI's denial concluded on April 10, 1991, when the Court of Appeals affirmed the Board's Order on Review that affirmed the referee's decision to set aside EBI's denial. At that time, EBI should have promptly reimbursed claimant's guardian for any of claimant's medical expenses that EBI had previously denied and that the guardian had paid. Then, EBI could have sought reimbursement from claimant's guardian for any expenses that it thought that it was owed under the parties' settlement agreement.

We will now proceed to interpret the parties' settlement agreement. We will return to the issues discussed in the preceding paragraphs once we have determined what the parties intended when they entered into that agreement.

The pivotal language of the settlement agreement is that: (1) EBI agreed to continue to pay claimant's workers' compensation benefits; and (2) claimant's guardian is to receive $5,000 per month from Mission, "which money is to be held for the benefit of EBI and used to satisfy EBI's future expenditures for compensation and other costs of the workers' compensation claim up to an amount of $60,000" plus the incremental increase. (Ex. 3-3).

That language could mean at least two things: First, it could mean that EBI would not seek reimbursement for any of claimant's medical expenses that exceeded $60,000, plus the incremental increase, in any given year. Second, it could mean that claimant's guardian agrees to hold all monies he receives from Mission in trust for EBI indefinitely, and that EBI may request up to $60,000, plus the increase, per year in reimbursement for expenses it incurs on claimant's behalf, regardless of the year in which the expenses are incurred. Given that ambiguity, we conclude that resort to extrinsic evidence of the parties' intent is proper. See Kenneth D. Orr, 44 Van Natta 1821 (1992); Roberta Zeulner, 41 Van Natta 2208 (1989).

In November 1983, First Colony (the third party liability carrier), EBI, and claimant agreed to a tentative settlement that, for payment by EBI of $218,000, EBI would be relieved of any further obligations to either claimant or his family. (Ex. 2a). Because this Board indicated that it would not approve such a settlement (apparently because it was contrary to former ORS 656.236), the third party, EBI and claimant's counsel began negotiations that resulted in the settlement agreement at issue here. (See Exs. 2b, 2c). In a letter to EBI, First Colony's counsel proposed the following terms for the settlement agreement:

> "[I]t is proposed that EBI will continue to service and provide workers' compensation benefits to [claimant's] personal representative as if no settlement occurred. However, every three months, EBI will present [claimant's] personal representative with a breakdown of its expenses which will be reimbursed quarterly and not to exceed $15,000 in any one quarter. The funds to provide any such reimbursement will exist as a result of the monthly structured payments to [claimant's] personal representative required by the parties' settlement agreement. Mission Insurance will hold EBI harmless, in effect guaranteeing that there will be quarterly reimbursements of $15,000 by [claimant's] personal representive." (Ex. 2c-2).

At the hearing, claimant's guardian testified that he understood the settlement agreement to mean that claimant's medical expenses would be reviewed on an annual basis and that, in any given year, EBI was responsible for any expenses that exceeded $60,000 plus the incremental increase. (Tr. 19). He did not, however, explain why that was his understanding.

EBI's counsel, at the time the ultimate settlement agreement was negotiated and executed, testified that the parties intended that EBI would be fully reimbursed for any further expenses incurred on claimant's behalf. (Tr. 31). He explained that, because the monies claimant's guardian received from Mission were to be held for EBI's benefit, if EBI did not expend $60,000 in a particular year, the parties intended that the difference would accumulate for use in future years. (See Tr. 32, 33).

We are persuaded that, in light of this evidence, the parties intended that EBI be relieved of any further obligations regarding claimant's workers' compensation benefits to the extent that claimant's guardian has received monies from Mission, subject to the qualification that the maximum reimbursement EBI could seek in any particular year is $60,000, plus the incremental increase. In other words, claimant's guardian is to hold indefinitely for EBI's benefit any monies it receives from Mission. EBI then may seek up to $60,000, plus the incremental increase, in reimbursement each year, with any unreimbursed sums that exceed the $60,000 limit being carried forward for reimbursement in future years.

This conclusion finds support in the parties' original and final agreements and First Colony's counsel's letter that proposed the terms of a settlement agreement. The original agreement, which this Board indicated that it would have disapproved, was designed to relieve EBI of any further obligations to claimant and his family. The final agreement plainly states that claimant's guardian is to hold the money for EBI's benefit, but is silent about how long the money is to be so held. This is a strong indication that the parties intended that the money be held indefinitely for EBI's benefit. The only purpose of holding such monies indefinitely could have been to relieve EBI of any further responsibility toward claimant and his family.

First Colony's counsel's letter supports this interpretation. The letter proposes that EBI be reimbursed quarterly in an amount not to exceed $15,000, from funds claimant's personal representative would receive from Mission. In turn, "Mission will hold EBI harmless, in effect guaranteeing that there will be quarterly reimbursements of $15,000 by [claimant's] personal representative." (Ex. 2c). This suggests that claimant's guardian (or personal representative) was to receive structured payments from Mission, which he was to hold indefinitely for EBI's benefit. Then, EBI could seek reimbursement from claimant's guardian up to $15,000 each quarter, regardless of when the expenses were incurred.

Although the terms of the parties' original agreement, the letter and the final settlement agreement are not identical, we conclude that the general intent underlying each document is the same; viz., that EBI would be relieved of all obligations to claimant, subject to the $60,000-plus per year reimbursement cap.

In reaching this conclusion, we note that the Referee relied on the Circuit Court order that authorized claimant's guardian to compromise claimant's and his wife's claims against the employer. That reliance is misplaced. First, EBI was not a party to the form of order. Therefore, it should not be bound by it. Second, the0order contains language that does not appear anywhere in the settlement agreement itself. (Compare Ex. 3a-5 to -6 with Ex. 3-3). For these reasons, we are persuaded to disregard the compromise order.

Having interpreted the parties' settlement agreement, we must now determine how to apportion any reimbursement. As explained above, EBI should have reimbursed claimant's guardian immediately at the close of the medical services denial litigation for any of claimant's medical expenses that the guardian had paid. Therefore, EBI is ordered to pay to claimant's guardian the difference between $67,530 and those of claimant's 1988 medical expenses that the guardian has paid. Claimant's guardian is then ordered to reimburse EBI for those claim costs on an annual basis, beginning as of 1991, in accordance with our interpretation of the settlement agreement. In the future, EBI will be entitled to annual reimbursement of up to $60,000, plus the incremental increase, for any future medical expenses incurred on claimant's behalf, regardless of the year in which the expenses are incurred.

Accordingly, we modify that portion of the Referee's order that concluded that EBI must reimburse claimant's guardian for medical bills that exceeded $67,530 in 1988.

PENALTIES AND ATTORNEY FEES

Finding that EBI had a legitimate doubt about its responsibility regarding claimant's "reimbursement" claim (in light of the parties' settlement agreement), the Referee held that claimant was not entitled to a penalty. Claimant argues that, because EBI unreasonably refused to reimburse his guardian for his 1988 medical bills, he is entitled to a penalty under ORS 656.262(10). We disagree.

ORS 656.262(10) authorizes an award of a penalty for unreasonable claims processing if a carrier has no legitimate doubt as to its liability. See International Paper Co. v. Huntley, 106 Or App 107 (1991). The carrier's "reasonableness" or "legitimate doubt" must be evaluated in light of the facts and circumstances that existed when the carrier began engaging in the purportedly unreasonable conduct. See Hutchison v. Fred Meyer, Inc., 118 Or App 288 (1993); Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, after claimant incurred the medical bills at issue, his guardian paid them. That course of action does not comport with the terms of the parties' settlement agreement; rather, as we explained earlier, EBI should have paid the bills, and then sought reimbursement from the guardian.

Nevertheless, such a determination regarding EBI's ultimate responsibility does not necessarily lead to the conclusion that its refusal to acquiesce in claimant's reimbursement request was unreasonable. Accordingly, notwithstanding that an earlier Referee had set aside EBI's denial of claimant's medical services claim, because claimant's guardian had already paid the bills, and because the language of this obviously complicated settlement agreement was subject to more than one interpretation (including that EBI would not be ultimately responsible for any claim expenses), we conclude that EBI had a legitimate doubt about its liability for claimant's medical bills. See Betty L. Robinson, 43 Van Natta 471 (1991) (insurer had legitimate doubt about its liability under oral settlement agreement where the parties' memorialization of agreement conflicted). Therefore, we affirm the Referee's conclusion that EBI's conduct was not unreasonable.

The Referee awarded claimant a carrier-paid attorney fee. The Referee cited Louise A. Greiner, 44 Van Natta 527 (1992), in which we granted an attorney fee award for unreasonable claim processing. ORS 656.382(1). Inasmuch as we have concluded that EBI's refusal to reimburse claimant's guardian was not unreasonable, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1). Accordingly, we reverse the Referee's attorney fee award.

Before we proceed to claimant's remaining attorney fee argument, we dispose of one potential additional attorney fee argument. The text of the Referee's "Order" does not specify a basis for the attorney fee award.[2] Although the Referee's "Opinion" purported to rely on Greiner, an unreasonable claims processing case, the Referee may have intended to award a fee under ORS 656.386(1). Assuming that that is what the Referee intended, we decline to award a fee under that statute because claimant does not argue it on review. See Mark D. Winn, 45 Van Natta 1282 (1993). In any event, ORS 656.386(1) is not applicable for the following reasons. First, we have concluded that EBI is entitled to full reimbursement for claimant's medical expenses. Thus, claimant has not "finally prevailed" against EBI's "denial," i.e., its refusal to reimburse claimant's guardian for claimant's medical expenses. Second, EBI has not contested the compensability of claimant's medical expenses (that is, their causal relationship to claimant's compensable injury). See SAIF v. Allen, 124 Or App 183 (1993); Caroline F. Wood, 45 Van Natta 2223 (1993). We now turn to claimant's remaining attorney fee argument.

Claimant argues that, on review, he is entitled to an attorney fee pursuant to ORS 656.382(2). We disagree.

ORS 656.382(2) authorizes an award of attorney fees when a claimant's benefits are at risk on appeal and the claimant prevails against a carrier's request for hearing, review or appeal. Even assuming that the Referee awarded claimant "compensation," claimant has not prevailed against EBI's request for review. Specifically, we have "reduced" the sum of monies that the Referee ordered EBI to pay claimant by stating that, although EBI must pay claimant's guardian for claimant's 1988 medical expenses, EBI is entitled to full reimbursement for those expenses. Accordingly, we conclude that ORS 656.382(2) does not apply.

INTEREST

The Referee declined to award claimant any interest. Claimant argues that, pursuant to ORS 656.313(1)(B)(b), he is entitled to interest on the amount of the medical bills that the earlier referee's order required EBI to pay. We disagree.

ORS 656.313(1)(B)(b) authorizes the accrual of interest on benefits withheld pending appeal that are ultimately found payable under a final order. That provision was enacted on July 1, 1990. See Or Laws 1990, ch 2, § 23. Because ORS 656.313(1)(B)(b) is not retroactive, it only applies when review of an order was sought after July 1, 1990. See Diamond Fruit Growers v. Goss, 120 Or App 390, rev den 317 Or 583 (1993). Accordingly, inasmuch as final review of claimant's medical services order was sought before July 1, 1990 (see Exs. 16, 17), ORS 656.313(1)(B)(b) does not apply to that litigation.

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[2] There is an apparent ambiguity in the Referee's order with respect to the attorney fee award. In her "Opinion," the Referee stated, "Claimant asks for penalties and attorney fees and interest. I find that penalties and attorney fees are not warranted given the unclear language of the settlement order." Opinion and Order at 5. However, in the next paragraph, the Referee concluded that claimant is entitled to a $3,000 attorney fee pursuant to Louise A. Greiner, supra.

To the extent that claimant seeks interest for any sums that either the Referee awarded him or that we have ordered EBI to pay him pursuant to this order, we decline to grant such a request. Inasmuch as EBI's obligation to pay interest is not ripe for adjudication pending its appeal, our consideration of any interest award with respect to this litigation would be premature. Gilbert T. Hale, 44 Van Natta 729 (1992).

ORDER

The Referee's order dated May 6, 1993, as amended on May 17, 1993, is modified in part and affirmed in part. EBI is ordered to pay claimant's guardian the difference between $67,530 and the amount of claimant's 1988 medical expenses that the guardian paid to Timber Ridge Ranch. Claimant's guardian is then ordered to reimburse EBI for those claim costs on an annual basis, beginning as of 1991, in accordance with our interpretation of the settlement agreement. That portion of the Referee's order that awarded claimant a $3,000 attorney fee pursuant to ORS 656.382(1) is reversed. The remainder of the Referee's order is affirmed.

February 11, 1994 Cite as 46 Van Natta 252 (1994)

In the Matter of the Compensation of
ALTAGRASIA LAMM, Claimant
WCB Case No. 92-14367
ORDER ON REVIEW
Susak, et al., Claimant Attorneys
Sandra K. Haynes, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Barber's order that dismissed her request for hearing as untimely filed. On review, the issue is timeliness.

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

On review, claimant argues that she has established good cause for her untimely filing, as she was mislead by the self-insured employer's claims examiner. Specifically, claimant contends that the claims examiner informed her that the denial letter would be "re-reviewed," and claimant would be contacted after that review. Claimant testified that, based upon that conversation, she believed that the first letter did not mean anything.

We have previously held that, where the carrier's employee did not inform a claimant that her claim would be accepted, the claimant's reliance on the carrier's statements did not constitute good cause for an untimely filing. Joe Ann Aguilar, 43 Van Natta 246 (1991); Diane T. Lindholm, 42 Van Natta 447 (1990). Here, the Referee found, and we agree, that the employer's claims examiner never told claimant to disregard the denial. The claims examiner specifically testified that at no time during any of her conversations with claimant did she inform claimant that the denial would be rescinded. (Tr. 42).

Under the circumstances, we agree with the Referee that claimant has failed to establish good cause for her untimely filing. The Referee's order is affirmed.

ORDER

The Referee's order dated June 10, 1993 is affirmed.

In the Matter of the Compensation of
JOSEPH D. McRORIE, Claimant
WCB Case No. 93-00353
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Nichols' order which set aside its March 24, 1993 denial of medical treatment for claimant's current dental condition, including peri-implantitis. On review, the issue is compensability.

We affirm and adopt the Referee's order, with the following supplementation. The court's recent decision in Beck v. James River Corp., 124 Or App 484 (1993) further supports the Referee's reasoning and conclusion. See also James R. Hittle, 46 Van Natta 65 (1994); compare Donald L. Myers, 46 Van Natta 53 (1994).

At hearing, the employer also contended that claimant's failure to follow his dentist's recommendations constituted insanitary or injurious practices which tend to imperil or retard recovery. See ORS 656.325(2). The employer notified claimant on March 24, 1993, advising him that his benefits may be suspended. (Ex. 25). However, the Referee found no evidence that the employer had applied to the Director for the suspension of benefits and concluded that ORS 656.325(2) was not applicable to the issue raised by the employer's denial.

In its appellate brief, the employer argues for the first time that claimant was not entitled to any workers' compensation benefits, pursuant to ORS 656.156(1), because his injury resulted from the "deliberate intention of the worker to produce such injury." This is a different issue from the one addressed by the Referee regarding the suspension of benefits under ORS 656.325. Specifically, this issue requires proof of intentional injury by the worker, an issue which was neither raised nor litigated at the hearing.

We decline to address an issue not raised before the Referee. Stevenson v. Blue Cross, 108 Or App 247 (1991). Moreover, we consider it to be fundamentally unfair to permit the employer to raise this defense at this late date. See Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993). Accordingly, we decline to address the employer's argument under ORS 656.156(1).

Inasmuch as claimant submitted no appellate brief, no attorney fee pursuant to ORS 656.382(2) shall be awarded. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated April 22, 1993 is affirmed.

In the Matter of the Compensation of
BENINO T. ORN, Claimant
WCB Case No. 92-15993
ORDER ON REVIEW (REMANDING)
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Referee Barber's order that affirmed the Director's order under ORS 656.327(2) which found a proposed surgery not to be appropriate medical treatment. With his brief, claimant submits a medical report not admitted at hearing. We treat such a submission as a motion for remand. ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). In its brief, the insurer contends that claimant's request for hearing was untimely. On review, the issues are remand, jurisdiction under ORS 656.327, and timeliness. We remand.

The Referee concluded that evidence existed in the record which supported the Director's order finding that proposed low back surgery was not appropriate treatment. Consequently, the Referee affirmed the Director's order. For the following reasons, we find that remand is appropriate.

We conclude that the Director did not have jurisdiction to review this medical services dispute pursuant to ORS 656.327. ORS 656.327(1) provides for review by the Director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." In Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time Director review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment. Moreover, the court determined that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 466, 467; Peter Britz, 45 Van Natta 2187 (1993).

Here, the dispute pertains to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, supra, the insurer was not entitled to Director review of the proposed surgery under ORS 656.327. Rather, the Hearings Division has original jurisdiction to resolve the dispute concerning the proposed surgery.

Furthermore, the proceeding before the Referee consisted only of reviewing the Director's findings for substantial evidence. See ORS 656.327(2). Consequently, it is apparent that the parties were presenting their respective positions under an inappropriate standard of review. Considering such a review standard, it is likewise apparent that the evidence was limited to that developed before the Director (since no testimony was offered nor any additional evidence allowed into the record other than that developed by the Director).

We may remand a case if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Given the posture of this case, we find a compelling reason to remand. See Patricia D. Simmons, 45 Van Natta 2305 (1993). Consequently, we conclude that the record is incompletely and insufficiently developed. See ORS 656.295(5). Therefore, we remand this case to the Hearings Division for further proceedings.

Because we have held that the Director did not have jurisdiction over this matter, resolution of the issue of timeliness of claimant's hearing request from the Director's order will not affect the outcome of this case. However, we note that we have previously held that the statute pertaining to Director's orders issued under ORS 656.327(2) contains no specific time period within which a party must seek a hearing. Vickie S. Moore, 45 Van Natta 2328 (1993). Here, the insurer cites to OAR 436-10-008(4)(b), and argues that claimant's request for hearing was untimely because it was filed with the Hearings Division more than 20 days after claimant received the Director's order.

OAR 436-10-008(3) provides that a "party aggrieved by an order of the Director pursuant to ORS 656.327(2) relating to any bona fide medical services dispute may request review by the Board's Hearing Division...as provided in ORS 656.283." OAR 436-10-008(3) provides no time period for such an appeal.

OAR 436-10-008(4)(b), the administrative rule cited by the insurer, pertains to proposed orders or proposed assessments of civil penalties issued pursuant to ORS 656.254 or 656.745, and provides that parties may request a hearing in accordance with ORS 656.740. OAR 436-10-008(4)(b). Accordingly, because this matter does not involve review of a proposed order regarding a penalty or noncomplying employer, we do not agree with the insurer's contention that the rule applies to this bona fide medical services dispute.

Furthermore, OAR 436-10-008(4)(a) and (b) provide that the request for hearing must be sent in writing to the administrator of the Workers' Compensation Division and must be filed "with the administrator of the Workers' Compensation Division within 20 days of receipt by the aggrieved person of notice of the proposed order or assessment." Such language referencing the Department, rather than the Board's Hearings Division, lends further support to our conclusion that the time period specified by OAR 436-10-008(4)b) does not apply to Director's bona fide medical service dispute orders under ORS 656.327(2). We conclude that the "hearing" referred to in OAR 436-10-008(4) is a hearing on penalties or noncomplying employer status, rather than a hearing on a bona fide medical services dispute. See ORS 656.740 (Person may contest a proposed order of the director declaring that person to be a noncomplying employer, or a proposed assessment of a civil penalty, by filing with the department, within 20 days of receipt of such notice, a written request for a hearing).

Finally, even if the rule was applicable to Director orders issued under ORS 656.327(2), the statute itself does not include a statutory time limit within which an appealing party may seek a hearing with the Board. Without such a statutory directive, we would not be inclined to rely on any rule which attempted to limit a party's right to request a hearing (particularly when the statute pertaining to Director's orders finding no bona fide dispute under ORS 656.327(1)(b) does expressly contain a specific time period to seek Board review).

Accordingly, if the "timeliness" issue was squarely before us, we would continue to conclude that there is no time period within which a party must seek a hearing from a bona fide order under ORS 656.327(2). Therefore, although it is not dispositive in this case, we disagree with the insurer's contention that claimant's request for a hearing from the Director's order was untimely.

Finally, as a result of our decision to remand, we need not address claimant's submission of additional medical reports on review. Rather, the Referee may consider the matter on remand. See Julie Sturtevant, 45 Van Natta 2344 (1993)(Evidence for consideration at hearing under ORS 656.327(2) is not limited to that developed before the Director).

Accordingly, the Referee's order dated April 22, 1993 is vacated. We remand to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall conduct further proceedings in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective positions regarding this dispute. Thereafter, the designated Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL R. PLEW, SR., Claimant
WCB Case Nos. 92-10047 & 92-08732
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Livesley's order that: (1) granted the SAIF Corporation's motion to dismiss claimant's untimely request for hearing from its denial of responsibility for claimant's right arm and shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for the same condition. On review, the issues are timeliness, compensability, and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness

We affirm and adopt that portion of the Referee's order regarding this issue.

Compensability/Responsibility

Claimant has an accepted bilateral carpal tunnel syndrome (CTS), right shoulder and left knee strain with Liberty. In February 1991, the claim closed. In September 1991, claimant began working at SAIF's insured, Wilson Tire. Claimant sought treatment for his right wrist and shoulder following work activities on February 27, 1992 when he used a sledgehammer to break down tires. Although both Liberty and SAIF denied compensability and responsibility, because we have affirmed that portion of the Referee's order dismissing claimant's request for hearing from SAIF's denial, we address only whether claimant proved a compensable aggravation and, if so, whether Liberty is responsible for claimant's condition.

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). Finally, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than the waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

Both Dr. Silver, family practitioner and claimant's treating physician, and Dr. Woolpert, orthopedic surgeon who examined claimant on behalf of SAIF, indicated that claimant's symptoms worsened following his work at Wilson Tire. (Exs. 60, 61, 67-18). Furthermore, there was evidence that the worsening resulted in a diminished earning capacity. As part of vocational assistance, claimant began work at Wilson Tire; the work was approved by claimant's then-treating physician. (Exs. 57-4, 57-13). Following the exacerbation, however, Dr. Silver restricted claimant from returning to work at Wilson Tire, recommending that he seek sedentary employment. (Exs. 60, 60A). There is no evidence that waxing and waning of claimant's condition was contemplated by the previous permanent disability award. Therefore, ORS 656.273(8) is not applicable. See Dana J. Fisher, 45 Van Natta 215 (1993).

With regard to causation, Dr. Silver stated that claimant's symptoms represented an exacerbation of his prior shoulder injury and that claimant's work at Wilson Tire contributed to his symptoms. (Exs. 60, 64). Similarly, Dr. Woolpert stated that both injuries contributed to claimant's need for treatment. (Ex. 67-21). In light of these opinions, we are persuaded that claimant's current right shoulder condition was directly caused by his work injury with Liberty and that, at a minimum, the "Liberty" injury is a material contributing cause of his current shoulder condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Rebecca J. Clark, 45 Van Natta 2050 (1993). Consequently, claimant has established a compensable aggravation claim with Liberty. See ORS 656.273(1).

This evidence further establishes that claimant sustained an accidental injury while working at SAIF's insured, Wilson Tire, and that claimant's preexisting shoulder condition combined with the accidental injury. Therefore, Liberty remains responsible for the claim unless claimant's injury at SAIF's insured was the major contributing cause of the need for disability or treatment for his resultant condition. See ORS 656.308(1); ORS 656.005(7)(a)(B); SAIF v. Drews, 308 Or 1 (1993).

Dr. Silver reported that claimant sustained an "exacerbation" that resulted from his work activities at Wilson Tire. (Exs. 60, 61). In one report, Dr. Silver reported that the "major contributing cause" was the work activities. (Ex. 64). In light of the previous reference to "exacerbation," we interpret Dr. Silver's opinion as indicating that claimant's work with SAIF's insured caused an increase of symptoms from his preexisting shoulder condition with Liberty. Such an opinion does not establish that claimant's work with SAIF's insured was the major contributing cause of the disability or need for treatment for claimant's resultant shoulder condition.

Dr. Woolpert reported that claimant's symptoms represented a "waxing and waning of his condition" rather than a "new or separate condition caused by recent work exposure." (Ex. 63B-4). Dr. Woolpert also indicated that the claimant's compensable injury was the "major contributing factor of his current condition." (Id). Dr. Woolpert did not alter his opinion during a subsequent deposition. (Ex. 67). The history upon which he based his opinion was consistent with claimant's testimony at hearing. (Ex. 63B-2, Tr. 22-24).

Based on our review of the aforementioned medical and lay evidence, we are not persuaded that claimant's injury with SAIF's insured was the major contributing cause of the disability or the need for treatment for his resultant shoulder condition. Consequently, we find that claimant did not sustain a "new compensable injury." ORS 656.308(1); ORS 656.005(7)(a)(B); SAIF v. Drews, supra. Therefore, we conclude that responsibility remains with Liberty.

Attorney Fees

Claimant is entitled to an attorney fee for services at hearing and on review for overturning Liberty's denials of compensability and responsibility. 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 is $4,600, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record, claimant's appellant's and reply briefs, and statement of services), the complexity of the issues, and the value of interest involved.

ORDER

The Referee's order dated January 22, 1993 is affirmed in part and reversed in part. That portion of the order finding Liberty not responsible is reversed. Liberty's denial is set aside and the claim is remanded to Liberty for processing in accordance with law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,600, to be paid by Liberty.

Board Member Haynes specially concurring in part and dissenting in part.

I concur with the majority's conclusion that claimant's request for hearing from SAIF's denial of responsibility was untimely and that the Referee properly granted SAIF's motion to dismiss. However, for the reasons stated below, I disagree with those parts of the order that address aggravation and award an attorney fee.

First, I would find that Liberty denied only responsibility. Liberty did not expressly deny compensability of claimant's aggravation. At hearing, Liberty's counsel did agree with the Referee's statement that the denial was amended to include compensability. But that argument was so ambiguous as to which party (Liberty/SAIF) was denying compensability, I cannot find that Liberty amended its denial to include compensability. Furthermore, the Referee's order, under "Issues", stated that claimant contested Liberty's denial of aggravation and responsibility. The Referee's order, however, discusses only whether responsibility shifted from Liberty; no part of the order discusses whether claimant proved a compensable aggravation or refers to ORS 656.273.

On review, claimant asserted that the Referee improperly found that his request for hearing from SAIF's denial was untimely and that Liberty was responsible for his wrist and shoulder condition. SAIF and Liberty filed respondents' briefs. Like the Referee, the parties limited their briefs to a discussion of responsibility and do not address compensability.

According to the majority, therefore, aggravation was raised by the Referee's statement that the denials were amended to include compensability and his reference in the order to a denial of aggravation. Our longstanding policy is not to address issues that are not raised at hearing. See e.g. Jeffrey D. Ward, 45 Van Natta 1514 (1993). My opinion is that this Board's policy demands a showing that the parties intended to actually contest a particular issue at hearing. Anything less results in inconsistency in that it allows the Board to address even the most nominally raised issues if such an approach is desired in a particular case. By completely ignoring what actually was addressed and discussed by the parties and the Referee, I think such a result was shown in this case.

In the Matter of the Compensation of
GARY WALLACE, Claimant
WCB Case Nos. 91-04678 & 90-17420
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Korner Kitchen Restaurant, requests review of those portions of Referee Herman's order which: (1) set aside its denial of claimant's new injury/occupational disease claim for a cervical condition; (2) upheld Liberty Northwest's denial of claimant's aggravation claim for the same condition, on behalf of Gee Gee's Restaurant; and (3) awarded claimant's counsel an assessed attorney fee of $3,000, payable by Liberty Northwest/Korner Kitchen. On review, the issues are responsibility and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of her ultimate finding that claimant sustained a new cervical injury.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant compensably injured his right shoulder and cervical spine in 1986 while employed by Gee Gee's Restaurant, insured by Liberty Northwest. The claim was closed by Determination Order that awarded no permanent disability. Claimant's former and current treating physician, Dr. Warren, last treated claimant for this injury on August 12, 1987.

After leaving his employment for Gee Gee's Restaurant, claimant worked for several intervening employers before coming to work for Korner Kitchen, also insured by Liberty Northwest, as a cook in November 1989. While claimant experienced intermittent cervical symptoms during this period, he did not require medical treatment.

On January 7, 1990, claimant experienced a significant increase in cervical pain during the course of the day shift at Kitchen Korner. There was no specific incident of injury. Claimant reported to the emergency room where severe cervical pain was diagnosed. Dr. Salisbury and Dr. Warren provided follow-up care. Their contemporaneous medical reports do not mention any new injury and relate claimant's cervical complaints to the 1986 injury. Liberty Northwest, on behalf of Gee Gee's Restaurant, initially denied compensability as well as responsibility, but later rescinded its compensability denial. Liberty Northwest/Kitchen Korner denied both compensability and responsibility.

The Referee determined that claimant's January 7, 1990 claim should be analyzed as an injury, rather than as an occupational disease, because claimant developed an acute cervical condition during a discrete period of time. The Referee further determined that claimant's work activities on January 7, 1990 were a material contributing cause of his need for treatment. Therefore, the Referee found that claimant had sustained a new independent injury for which Liberty/Korner Kitchen was responsible. Because Liberty/Korner Kitchen denied compensability as well as responsibility, the Referee also assessed an attorney fee of $3,000, payable by Liberty/Korner Kitchen.

We consider first whether ORS 656.308(1) applies to this claim. To answer this question we need to determine if claimant's current condition for which he seeks compensation involves the "same condition" as the prior accepted cervical claim processed by Liberty/Gee Gee's. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993); Beverly R. Tillery, 43 Van Natta 2472 (1991).

The initial medical reports from Drs. Salisbury and Warren indicate that the cervical injury for which they provided treatment in January 1990 and thereafter was the same condition that resulted from claimant's original cervical injury on November 22, 1986. (Exs. 27C, 28, 28B, 29-1, 29A, 31). Based on this evidence, we find claimant's current condition involves the "same condition" as the condition for which Liberty/Gee Gee's is responsible. Therefore, ORS 656.308(1) is applicable to this claim.

Under that statute, Liberty/Gee Gee's remains responsible for claimant's future compensable medical services and disability relating to the compensable condition unless claimant sustains a "new compensable injury" involving the same condition. Id. Subsequent to the Referee's order, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). The Court ruled that 0he major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). To establish a new injury, Liberty/Gee Gee's must show that claimant's employment activities on January 7, 1990 were the major contributing cause of claimant's disability or need for treatment.

ORS 656.308 is also intended to encompass occupational disease claims. Liberty Northwest Insurance Corporation v. Senters, 119 Or App 314 (1993). Thus, in order to establish a new occupational disease, the carrier with an accepted claim has the burden of establishing that subsequent work activities were the major contributing cause of the claimant's disease or its worsening. See ORS 656.802(2); Senters, supra; Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991).

An occupational disease is distinguished from an injury in two ways: (1) a disease is not unexpected inasmuch as it is recognized as an inherent hazard of continued exposure to conditions of the particular employment; and (2) it is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1980); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). The court has construed the phrase "sudden in onset" to mean occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, 56 Or App 184, 188 (1982).

We agree with the Referee that the January 7, 1990 claim should be analyzed as an accidental injury, as opposed to an occupational disease claim. Although claimant was symptomatic prior to January 7, 1990, he never required medical treatment. In addition, claimant experienced an acute onset of cervical pain during a discrete period of time while working the day shift at Korner Kitchen. Valtinson, supra.

Regardless of whether this claim is analyzed as an injury or an occupational disease, Liberty/Gee Gee's has the burden of proving that claimant's employment at Korner Kitchen is the major contributing cause of claimant's current cervical condition. ORS 656.308(1); Drews, supra; Senters, supra.

Here, because of the various possible causes of claimant's cervical condition, including the prior compensable injury and his continued work activities, we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

We do not find that the medical evidence establishes that claimant's work activities on January 7, 1990 were the "major contributing cause" of claimant's disability and need for medical treatment. We

are particularly persuaded by the contemporaneous medical reports from Drs. Salisbury and Warren which clearly relate claimant's cervical condition to the original compensable injury in 1986. (Exs. 27C, 28, 28B, 29-1, 29A, 30, 31). Granted, claimant sought no medical treatment between August 17, 1987 and January 8, 1990. However, claimant was not asymptomatic during this period and he reported no specific incident of injury on January 7, 1990.

We are mindful that both Dr. Salisbury and Dr. Warren later agreed that claimant's work on January 7, 1990 was the "major contributing cause" of claimant's disability and need for treatment. (Exs. 40, 41, 43). However, these were "check-the-box" opinions given in response to letters drafted by counsel for Gee Gee's. Accordingly, we give them little weight. See David J. Rowley, 45 Van Natta 1659 (1993). In any event, these opinions are not more persuasive than the contemporaneous medical reports that relate claimant's cervical condition to the original 1986 cervical injury and do not mention claimant's work activities for Kitchen Korner as the major factor in claimant's cervical condition in January 1990.

For the above reasons, we conclude that Liberty/Gee Gee's has not sustained its burden of proving that claimant sustained a new injury or occupational disease during his employment at Korner Kitchen. Accordingly, we reverse the Referee's order.

Attorney Fees

At hearing, claimant's right to compensation was at risk due to Liberty/Korner Kitchen's denial of compensability. That denial justifiably prompted claimant's active participation at hearing to protect his right to compensation. Liberty/Gee Gee's denied responsibility only and, therefore, did not place claimant's compensation at risk. Since Liberty/Korner Kitchen created the need for claimant to establish the compensability of his claim, Liberty/Korner Kitchen remains responsible for the Referee's $3,000 attorney fee for services at the hearing level. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993); SAIF v. Bates, 94 Or App 666 (1989).

Furthermore, claimant's compensation was also at risk on Board review due to Liberty/Korner Kitchen's appeal. Because claimant's compensation was not disallowed or reduced on appeal, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, also payable by Liberty/Korner Kitchen. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by Liberty/Korner Kitchen. 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 9, 1993 is reversed in part and affirmed in part. Liberty/Korner Kitchen's denial is reinstated and upheld. Liberty/Gee Gee's denial is set aside and the claim is remanded to Liberty/Gee Gee's for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by Liberty/Korner Kitchen.

In the Matter of the Compensation of
SIEGMAR R. REINIGER, Claimant
WCB Case No. C4-00036
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Patrick Lavis, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig & Gunn.

On January 5, 1994, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On January 24, 1994, the Board requested that the parties submit an addendum to the CDA to conform the attorney fee amount to that provided by OAR 438-15-052, or to indicate extraordinary circumstances justifying the fee.

The original CDA referenced only one claim and one date of injury. Yet, the CDA also included two summary pages, each providing a separate sum of money for two accepted conditions (low back and major depression). Additionally, separate attorney fee amounts were based on the separate proceeds. Specifically, the first summary page provided that, for the low back condition, claimant would receive $7,500 and claimant's attorney would receive $2,500. The second summary page provided that claimant would receive $7,125 and claimant's attorney would receive $2,375.

The Board has allowed two claims to be disposed of with one CDA, as long as a separate summary page is submitted for each claim. See Julie K. Gasperino, 45 Van Natta 861 (1993); Jerry H. Foss, 43 Van Natta 48 (1991). Furthermore, each claim must have a separate amount of consideration, in addition to providing all of the information required by the Director's rules for each claim. Foss, supra.

Here, however, there is only one claim with one date of injury. Therefore, because only one claim is involved, by providing a separate sum of money for each condition on a separate summary sheet, and calculating an attorney fee based on each separate sum, the parties' original agreement concerning the proposed attorney fee exceeded the attorney fee limit provided by OAR 438-15-052. Furthermore, the agreement did not indicate any extraordinary circumstances justifying the fee.

On February 8, 1994, the parties submitted an addendum to the CDA. The addendum amended the second summary page of the CDA (major depression condition) to provide that the total due claimant is $8,175, and the total attorney fee is $1,325. Accordingly, the total due claimant under claim number C604-162581, with the date of injury of September 17, 1987, is $15,675 and the attorney fee is $3,825, which is in compliance with the rule.

The amended agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' amended claim disposition agreement is approved. An attorney fee of $3,825, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORI A. AUTERSON, Claimant
WCB Case No. 92-14724
ORDER ON REVIEW (REMANDING)
Gatti, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Herman's order that: (1) found that she was not entitled to temporary partial disability; and (2) declined to assess penalties and related attorney fees for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability, penalties and attorney fees. We remand.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's order, with the following correction. We replace the reference to "Dr. Miller" in the fourth sentence in the second paragraph on page two with "Dr. Moore."

CONCLUSIONS OF LAW AND OPINION

Following the October 1992 compensable nondisabling injury, claimant was released to perform light-duty work. Her wages were not affected by the change in work assignment. Claimant continued to work for the employer on a modified basis until she requested, and was granted, a leave of absence for personal reasons on January 11, 1993. The employer did not pay temporary disability after claimant began modified employment, and claimant requested a hearing.

The Referee found that claimant, who was injured the fifth day on the job, had been hired as a part-time employee. See OAR 436-60-025(5)(a) (for workers employed less than four weeks, the intent at the time of hire is used to determine claimant's average weekly wage). Further, reasoning that claimant had not suffered any reduction in wages as a result of returning to modified work, the Referee concluded that claimant was not entitled to temporary partial disability (TPD) because her wages at modified work were the same or greater than at the time of injury. See OAR 436-60-030(2) (temporary disability benefits not due where post-injury wages are equal to or greater than at-injury wages).

We agree with and adopt the Referee's reasoning and conclusions that the intent at time of hire was to employ claimant as a part-time worker. That, however, does not end our inquiry. Subsequent to the Referee's decision, in Stone v. Whittier Wood Products, 124 Or App 117 (1993), the court concluded that TPD must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that OAR 436-60-030(2) was inconsistent with ORS 656.212 in that the rule restricts TPD to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work as required by the statute).

In reaching its conclusion, the Stone court reasoned that an injured worker's post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

Here, other than evidence confirming that claimant's at-injury wage was not affected by her return to work in a light-duty position, there is essentially no documentary or testimonial evidence in the record regarding claimant's "earning power at any kind of work." In light of such circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's temporary partial disability caused a proportionate loss of earning power at any kind of work. (We do not consider the record to be incompletely or insufficiently developed to determine whether claimant was a part-time or full-time employee, as evidenced by the fact that we have herein found that claimant was hired as a part-time worker).

Because this record was developed prior to the Stone court's interpretation of ORS 656.212 and its attention to diminished earning power at any kind of work in calculating TPD, the parties did not have an opportunity to present evidence or argument on this crucial issue. Therefore, we find that there is a compelling reason to remand for the submission of additional evidence solely concerning claimant's loss of earning power at any kind of work. See ORS 656.295(5); Troy Shoopman, 46 Van Natta 21 (1994).

Accordingly, we vacate the Referee's order dated March 15, 1993. This matter is remanded to the Presiding Referee to assign a referee to hold further proceedings consistent with this order. Those proceedings may be conducted in any manner that the assigned Referee determines will achieve substantial justice, although we would recommend that evidence concerning claimant's employment history (including past/current wages) be presented. See Shoopman, supra at 22 n.2. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

February 16, 1994 Cite as 46 Van Natta 263 (1994)

In the Matter of the Compensation of
PHILLIP H. BATTON, Claimant
WCB Case No. 92-14140
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Swensen & Gray, Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes, and Hall.

Claimant requests review of that portion of Referee Nielsen's order that upheld the SAIF Corporation's denial of claimant's injury claim for a cervical disk herniation. The sole issue on review is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set forth in the "Facts" portion of her Opinion and Order. We further find that claimant had a preexisting degenerative condition throughout his cervical spine.

CONCLUSIONS OF LAW AND OPINION

Claimant undisputedly developed or suffered a disc herniation at C6-7 in or around May or June 1992. Claimant contends that he developed the condition on June 19, 1992 as the result of a lifting incident at work on that day. Claimant relies on the opinion of Dr. Brett, the treating physician, that the condition was caused in major part by a lifting incident at work on June 11, 1992. SAIF contends that Dr. Brett's opinion is based on an inaccurate history and is, therefore, not persuasive.

The Referee concluded that claimant did not injure himself at work as he had reported to Dr. Brett. The Referee based her negative credibility finding, in substantial part, on inconsistencies in the record relating to collateral matters that have no bearing on the issues before us. The collateral matters do not support the Referee's adverse credibility finding.

Nevertheless, we conclude from our review of the record, that Dr. Brett's opinion is not persuasive because it is based on an inaccurate history concerning when and how claimant's left side problems began. Specifically, Dr. Brett understood that they began on June 11, 1992, as a result of a lifting incident on that date. However, claimant was adamant at hearing that the lifting incident occurred on June 19, 1992, his last day of work, and that he "never had any left-side discomfort or symptoms [before] the incident [he] described." (Tr. 75). This discrepancy is problematical.

Claimant first reported his left side symptomatic flareup to Dr. Brett on June 11, 1992. At that time, he complained of right and left-side symptoms. (Ex. 14-1). Dr. Brett believed the pain reports were severe enough to warrant repeat neck films and magnetic imaging and a reassessment the following week. Dr. Brett related the problem to claimant's prior work injury in the state of Washington in 1990. (Id).

Claimant returned to Dr. Brett on June 22, 1992, with increasing left-sided neck discomfort and radicular left arm pain. (Ex. 14-2). Again, there is no reference to any lifting incident at work. Rather, the first reference to a lifting incident appears in Dr. Brett's June 24, 1992 chart note. (Ex. 14-2). This note states that claimant "returns today still having his neck and referred interscapular pain and mainly left upper extremity pain," and then describes a lifting incident on June 11, 1992 causing the immediate development of claimant's left-side problem. (Ex. 14-2). As the June 24, 1992 chart note clearly reflects, Dr. Brett believed that the alleged work incident occurred on or before June 11, 1992, which would account for the left-side symptoms claimant had reported to him during the examination of that date. However, if claimant's testimony at hearing is to be believed, the lifting incident occurred on June 19, 1992, more than one week after the onset of claimant's left-side symptoms. We are unable to determine whether Dr. Brett would have reached the same opinion on causation if he had understood that the alleged incident occurred more than a week after the symptoms first appeared. Moreover, we also do not know what Dr. Brett would have opined had he been aware of claimant's fence building activities in late May or early June and his complaints of pain following them. There are no other medical opinions in the record on the question of causation. Accordingly, we conclude that claimant has not established the compensability of his herniated cervical disk.

ORDER

The Referee's order dated May 17, 1993 is affirmed.

Board Member Hall dissenting.

Claimant's treating physician, Dr. Brett, has opined that claimant's C6-7 disk herniation was caused in major part by a lifting incident at work. There is no contrary medical opinion. Nevertheless, the majority has upheld SAIF's denial of this claim because, in one report, Dr. Brett mistakenly identified the date of the work incident as June 11, 1992, rather than June 19, 1992. Notwithstanding this misstatement, I am persuaded that claimant has carried his burden of establishing the compensability of his claim.

Claimant had a prior December 1990 work injury, resulting in a right C4-5 disk herniation. Dr. Brett began treating claimant for this injury. Claimant returned to Dr. Brett on June 11, 1992, complaining of bilateral neck symptoms. At that time, Dr. Brett reported that claimant was objectively unchanged and related claimant's symptoms to the December 1990 injury. When Dr. Brett reexamined claimant on June 22, 1992, he noted a worsening in claimant's condition from his earlier examination on June 11, 1992. Subsequent diagnostic studies confirmed a left C6-7 disk herniation.

The worsening Dr. Brett observed at the June 22, 1992 examination corroborates claimant's report of a lifting incident between the June 11 and June 22 examinations. It was after Dr. Brett observed this worsening that he related claimant's C6-7 disk herniation to the recent lifting incident at work, rather than the December 1990 work injury. Dr. Brett based his opinion on an accurate history of the mechanics of the lifting incident. Any confusion over the precise date of the work injury does not change the fact that claimant's condition worsened after that incident. Moreover, claimant's worsened condition provides a reasonable basis for Dr. Brett's opinion.

The majority's suggestion that Dr. Brett's opinion was, instead, based on a June 11, 1992 injury date is mere conjecture. I would not discard Dr. Brett's uncontradicted medical opinion based on such a conjecture, especially in light of other supporting medical evidence in the file. Dr. Fuller, a consulting medical examiner, also opined that claimant's work incident was the major cause of his herniated disk. He did so with full knowledge of claimant's initial treatment by Dr. Brett on June 11, 1992, prior to the reported lifting incident at work on June 19, 1992.

For these reasons, I disagree with the majority's decision to disregard the uncontradicted medical opinion of claimant's longstanding treating physician.

In the Matter of the Compensation of
NIKKI BURBACH, Claimant
WCB Case Nos. 92-00795 & 92-03860
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Scott Terrall & Associates, Defense Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Barrett Business Services (BBS), a self-insured employer, requests review of those portions of Referee Podnar's order that: (1) set aside its denials of claimant's current right knee condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (3) awarded an attorney fee under ORS 656.382(1) for a discovery violation. Claimant cross-requests review of those portions of the Referee's order that: (1) neglected to specify that a penalty against BBS for an allegedly untimely acceptance was 25 percent; (2) neglected to specify that a penalty against BBS for a discovery violation would be 10 percent of compensation due after October 29, 1991; (3) declined to find that BBS's claim processing conduct constituted an improper "de facto" denial of a right knee meniscus tear; and (4) awarded claimant's counsel a carrier-paid attorney fee of $4,000. On review, the issues are compensability, responsibility, penalties and attorney fees. We reverse in part, modify in part, vacate in part, and affirm in part.

FINDINGS OF FACT

On May 3, 1991, while performing her job as a waitress for BBS, claimant struck her right knee on a table. On May 19, 1991, claimant's right knee gave out at work after she squatted to refill a cooler. (Tr. 21; Exs. 1; 3; 3A). BBS accepted claimant's injury claim on October 1, 1991 for a right knee contusion. (Ex. 10).

An MRI of claimant's right knee was performed on August 29, 1991. This study revealed no fracture, joint effusion or meniscal tear. (Ex. 9). Claimant was off work from May 19, 1991 until September 24, 1991 when she went to work as a waitress for SAIF's insured. (Tr. 22-23; 24). Claimant continued to have pain symptoms in the right knee after the May 19, 1991 injury. (Ex. 12; Tr. 26; 29-30; 45-46).

On October 29, 1991, claimant was seen at the emergency room for right knee pain. Claimant reported that her right knee gave out when she bent down to pick up napkins while working for SAIF's insured. (Ex. 14).

In November 1991, claimant saw Dr. Baldwin, orthopedic surgeon, who diagnosed a resolving contusion. (Ex. 17). A November 13, 1991 bone scan was normal. (Ex. 18). A November 15, 1991 arthrogram revealed no tears of the menisci, but did reveal a moderate-sized Baker's cyst. (Ex. 18).

On November 18, 1991, Dr. Baldwin sought authorization for an arthroscopy to rule out a suspected meniscus tear. (Exs. 21; 24). Dr. Baldwin further requested that claimant be placed on temporary disability beginning October 29, 1991 until claimant had recovered from the proposed arthroscopy surgery.

On December 10, 1991, Johnston & Culberson (then the processing agent for BBS) denied compensability of claimant's current condition and need for treatment. (Ex. 22).

On December 11, 1991, claimant's attorney requested copies of claim documents from Johnston & Culberson. Effective December 30, 1991, Sedgwick James became the claim processing agent for BBS. (Ex. 23A). The requested claim documents were provided to claimant's attorney by Sedgwick James (on behalf of BBS) on January 7, 1992.

On January 31, 1992, a $500 civil penalty was assessed by the Director against BBS for providing the claim documents 12 days late. (Ex. 24A). The civil penalty was later reduced to $100. (Ex. 37).

On February 24, 1992, Sedgwick James (on behalf of BBS) issued an amended denial which denied claimant's Baker's cyst and responsibility for claimant's right knee condition. (Ex. 25). Claimant subsequently filed a claim against SAIF's insured for the October 29, 1991 squatting incident. On March 16, 1992, SAIF issued a disclaimer of responsibility and claim denial. (Ex. 28). On June 22, 1992, SAIF issued an amended denial which denied the compensability of claimant's claim on the ground that claimant's preexisting knee condition rather than her October 1991 injury was the major contributing cause of her disability and need for treatment. (Ex. 34).

On June 23, 1992, claimant underwent arthroscopic surgery. A tear of the medial meniscus was discovered and a partial medial meniscectomy was performed. (Ex. 34A).

At the November 23, 1992 hearing, claimant's attorney listed the issues as: compensability, responsibility, and temporary disability (this issue was deferred for later resolution). Claimant's attorney also raised penalties and attorney fees based on the following grounds: (1) an alleged discovery violation; (2) an unreasonable denial by BBS; (3) a preclosure denial by BBS; (4) an alleged "de facto" denial by BBS of claimant's right meniscus tear claim; and (5) the scope of BBS's acceptance. (Tr. 3-9).

Dr. Baldwin, claimant's treating surgeon, opined that the May 1991 injury while claimant was employed by BBS, was the major contributing cause of claimant's need for arthroscopic surgery. (Ex. 31). Dr. Baldwin further opined that claimant's medial meniscus tear most likely resulted from the May 19, 1991 BBS injury and was probably aggravated by the October 1991 injury at SAIF's insured. (Ex. 35).

Dr. Tesar also felt that claimant's medial meniscus tear occurred on May 19, 1991. (Ex. 38). Dr. Tesar believed that the October 1991 injury at SAIF's insured aggravated claimant's preexisting knee condition and pathologically worsened that condition. Dr. Tesar opined that the October 1991 injury materially contributed to claimant's need for treatment and eventual partial medial menisectomy. (Ex. 38).

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's right knee condition compensable and held BBS responsible for that condition. The Referee also assessed a penalty against BBS for the "late acceptance" of claimant's right knee contusion (based on all compensation due between May 19, 1991 and October 1, 1991), and assessed a $500 penalty-related attorney fee against BBS for a discovery violation. In the "opinion" section of the order, the Referee assessed a 10 percent penalty for BBS' discovery violation (based on all compensation due after October 29, 1991). Finally, the Referee awarded claimant's counsel a $4,000 assessed attorney fee pursuant to ORS 656.386(1) for prevailing over BBS's denials.

Preliminary Matter

We note that the Referee's order indicates that only Exhibits 1 through 28 and 30 through 38 were admitted into evidence. However, the record was specifically left open for a deposition of Dr. Tesar and the Referee's order refers to Dr. Tesar's deposition (Ex. 39). Moreover, the parties rely on Exhibit 39 in their briefs. No party has raised any evidentiary objections. Accordingly, we conclude that the Referee intended to admit, and implicitly did admit, Dr. Tesar's deposition (Exhibit 39) into evidence. See Aletha R. Samperi, 44 Van Natta 1173, 1174 (1992); Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991). Therefore, we have considered the deposition in conducting our review.

Compensability

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); John G. Davison, Dcd, 45 Van Natta 389 (1993), aff'd mem Davison v. McDonnald & Weltel, 125 Or App 338 (1993). 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 Hospital v. Gasperino, supra.

Here, the medical evidence is unanimous that claimant's right knee condition (meniscus tear) arose directly from the May 19, 1991 industrial accident. (Exs. 35; 38; 39). As a result, to establish compensability of the right knee condition, claimant need only establish that the May 19, 1991 work injury is a material contributing cause of her right knee condition (meniscus tear).

Two physicians address the cause of claimant's right knee condition. Dr. Baldwin is claimant's treating orthopedic surgeon and performed claimant's right arthroscopic knee surgery. He opined that the major contributing cause of claimant's need for treatment and disability is the May 19, 1991 injury. His final diagnosis of claimant's right knee condition was a tear of her medial meniscus with resultant secondary Baker cyst. He explained:

> "It is my feeling that this condition is the result of her May 3 and/or May 19 injuries. This condition was probably aggravated in the October incident. It is not my feeling that the condition is attributable to both injuries. The tear most likely arose on the May 19th injury when she was squatting and her knee gave way."

Dr. Tesar, orthopedic surgeon, performed a records review on behalf of BBS. He opined that claimant tore her medial meniscus on May 19, 1991 when she squatted at work. He further opined that claimant's October 1991 injury at SAIF's insured aggravated the preexisting tear and aggravated claimant's pain causing her to be unable to return to work. Tesar opined that the injury at SAIF's insured materially contributed to claimant's need for treatment and eventual partial medial meniscectomy.

All of the medical evidence indicates that claimant's right knee condition is compensable, Accordingly, based on the uncontroverted medical evidence, claimant has established that her right knee condition is compensable. Having established that claimant's right knee condition is compensable, we now determine which carrier is responsible for that condition.

Responsibility

In determining whether a claimant sustained a "new compensable injury" under ORS 656.308(1), the Supreme Court has held that ORS 656.005(7)(a)(B) is applicable. SAIF v. Drews, 318 Or 1 (1993). In other words, the Court has reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, the Supreme Court has further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

Here, both Drs. Tesar and Baldwin opined that the October 29, 1991 injury at SAIF's insured "aggravated" claimant's preexisting medial meniscus tear and resulted in increased symptoms and further disability. We interpret these physicians' opinions to mean that the October 29, 1991 injury combined with claimant's preexisting knee condition to cause or prolong disability or a need for treatment. Thus, in order for responsibility to shift from BBS to SAIF, BBS must establish that the October 29, 1991 injury at SAIF's insured is the major contributing cause of claimant's disability and need for treatment.

Dr. Baldwin has indicated that the May 19, 1991 BBS injury is the major contributing cause of claimant's disability and need for treatment of the right knee. Dr. Tesar has also indicated that claimant's meniscal tear arose from the May 19, 1991 compensable injury. Dr. Tesar has further indicated that the October 29, 1991 injury materially contributed to the condition and that the October 1991 injury caused a pathologic worsening of the right knee condition. Dr. Tesar did not indicate, however, that the October 29, 1991 injury at SAIF's insured was the major contributing cause of the meniscal tear. In any event, we rely on the opinion of Dr. Baldwin, who is claimant's treating physician and who performed claimant's right knee surgery. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983); see also Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

Based on this record, we conclude that BBS has not established that the major contributing cause of claimant's disability and need for treatment is the October 29, 1991 injury with SAIF's insured. Accordingly, responsibility for claimant's compensable right knee condition remains with BBS (Sedgwick James).

Penalty for Late Acceptance of Right Knee Contusion Claim

The Referee assessed a 25 percent penalty against BBS for a late acceptance of claimant's right knee contusion. On review, BBS contends that claimant did not raise the issue of an untimely acceptance of the right knee contusion claim at hearing. At hearing, claimant's attorney raised the following penalty and attorney fee issues: (1) an alleged discovery violation; (2) an allegedly unreasonable denial; (3) a preclosure denial by BBS; (4) an alleged "de facto" denial by BBS of claimant's right meniscus tear claim; and (5) the scope of BBS's acceptance. (Tr. 3-9).

The record reveals that claimant did not raise the issue of a penalty for a late acceptance of her right knee contusion claim at hearing. A Referee's review is limited to issues raised by the parties. Jeffrey D. Ward, 45 Van Natta 1513 (1993); Michael B. Petkovich, 34 Van Natta 98 (1982). Inasmuch as claimant did not raise the issue of a penalty for late acceptance of the right knee contusion claim, we vacate that portion of the Referee's order which purported to address that issue and which assessed a 25 percent penalty against BBS for late acceptance of the right knee contusion claim. See Jeffrey D. Ward, supra.

Penalty/Fee for Alleged "De Facto" Denial of Right Meniscal Tear

Claimant has asserted on review that BBS "de facto" denied her claim for a right knee meniscal tear. Claimant asserts that since there was a "de facto" denial of her claim for a right knee meniscus tear, she is entitled to a penalty for an unreasonable delay in accepting or denying the claim as well as an attorney fee for overturning the alleged "de facto" denial. We disagree.

On November 18, 1991, Dr. Baldwin wrote to BBS's then claims processing agent stating that he suspected a tear of the right medial meniscus. He requested permission to perform an arthroscopy to determine whether such a tear existed. In addition, Dr. Baldwin sought temporary disability for claimant. On December 10, 1991, in response to that request, BBS's claims processor issued a partial denial of claimant's current right knee condition and need for treatment. Thus, there was an explicit denial of the proposed surgery; i.e. need for treatment. Since that surgery was designed to investigate the existence of a medial meniscus tear, it likewise follows that the denial also encompassed that suspected condition. Because there was no "de facto" or untimely denial of the claim, penalties and attorney fees are inappropriate.

Penalty and Attorney Fee for Late Discovery

The Referee assessed a 10 percent penalty against BBS for late provision of discovery pursuant to ORS 656.262(10). The Referee also awarded a $500 assessed attorney fee pursuant to ORS 656.382(1) for the discovery violation. BBS concedes that, as a result of its change in processing agents, it provided discovery documents to claimant's attorney 12 days late.

In light of the BBS's concession that it provided discovery late, we conclude that its conduct was unreasonable. Since neither party objects to the amount of the penalty assessment, we also affirm the Referee's 10 percent penalty. The penalty shall be based on amounts "then due" (as a result of the Referee's order finding the claim compensable) on the date of BBS's January 7, 1992 untimely disclosure of claims documents. See Jeffrey D. Dennis, 43 Van Natta 857 (1991) (the delay period is the "then" with regard to the term "amounts then due"). One half of the penalty shall be paid to claimant and one half shall be paid to claimant's attorney.

Although we agree with the Referee that a penalty is appropriate, we reverse the Referee's assessment of a $500 penalty for the same unreasonable conduct.

Where a carrier's misconduct is such that a penalty may be assessed under ORS 656.262(10), no fees are available under ORS 656.382(1). Oliver v. Norstar, Inc., 116 Or App 333 (1992); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Here, because there were amounts "then due" at the time of BBS's unreasonable conduct, a penalty is assessable under ORS 656.262(10) for BBS's discovery violation. Thus, claimant is not also entitled to an attorney fee pursuant to ORS 656.382(1) in addition to the ORS 656.262(10) penalty.

Attorney Fee/Hearing Level

The Referee awarded claimant's attorney an assessed fee of $4,000 for services at hearing. Contending that the Referee's award was inadequate, claimant seeks an increased award. We find the Referee's attorney fee award to be reasonable.

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, claimant's counsel's statement of services, and considering the above factors, we conclude that the Referee's award is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that claimat's attorney might go uncompensated. We also note that claimant's counsel is not entitled to an attorney fee under ORS 656.386(1) for services devoted to the penalty and attorney fee issues raised at hearing.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over BBS'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 $1,500, to be paid by BBS. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issues, the value of the interest involved and the risk that claimant's attorney might go uncompensated. We further note that claimant is not entitled to an attorney fee for services on review devoted to her counsel's unsuccessful efforts regarding the penalty and attorney fee issues.

ORDER

The Referee's order dated March 9, 1993, as amended on March 15, 1993, is reversed in part, modified in part, vacated in part and affirmed in part. That portion of the Referee's order that awarded a $500 penalty-related attorney fee is reversed. That portion of the Referee's order that awarded a penalty for BBS's late provision of discovery is modified. A penalty of 10 percent of the amounts then due (as a result of the Referee's order finding the claim compensable) on the date of BBS's January 7, 1992 untimely disclosure is assessed against BBS. One half of the penalty shall be paid to claimant and one half shall be paid to claimant's attorney. That portion of the Referee's order which assessed a 25 percent penalty against BBS for late acceptance of a right knee contusion claim is vacated. The remainder of the Referee's order is affirmed. For services on review, claimant's attorney is awarded $1,500 payable by BBS.

In the Matter of the Compensation of
WILLIAM A. BURT, Claimant
WCB Case Nos. 93-01778 & 92-14808
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

United Employers Insurance Company (UEI) requests review of Referee Michael Johnson's order that directed it to pay a $4,300 attorney fee as previously awarded by a final litigation order. On review, the issue is attorney fees.

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

A prior referee's order found UEI responsible for claimant's compensable low back condition. The prior referee awarded a $4,300 attorney fee to claimant's attorney, payable by UEI. The portion of the prior referee's order which set aside UEI's denial and the portion which awarded claimant's counsel an attorney fee were in separate sections of the order. (Ex. 4). UEI appealed the prior referee's order, raising as issues all issues decided adversely to it.

On October 30, 1990, we found a noncomplying employer, Adams Landscape Service (Adams), responsible for the low back claim. William A. Burt, 42 Van Natta 2450 (1990). Our order expressly stated as follows:

> "The Referee's order dated April 24, 1989 is reversed in part and affirmed in part. United Employers Insurance Company's denial is reinstated and upheld. The SAIF Corporation's denial as processing agent for the noncomplying employer, Adams Landscape Service, is set aside, and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed." (Ex. 5). (Emphasis supplied).

The order neglected to either expressly address or reverse the referee's award of a $4,300 assessed attorney fee payable by UEI. Instead, after reversing the prior referee on the responsibility issue, the order specifically affirmed the remainder of the referee's order. Inasmuch as claimant's attorney fee payable by UEI was a remaining portion of that referee's order, we agree with the Referee that this phrase included the Referee's UEI-paid attorney fee award.

Our October 30, 1990 order was appealed by SAIF to the Court of Appeals. Our order has been affirmed. SAIF v. Burt, 114 Or App 12 (1992). The only issue raised before the court was responsibility; the prior referee's attorney fee awards were not challenged before the court.

While our prior order may well have been in error, UEI's remedy was to seek reconsideration of our order, or to appeal the attorney fee portion of the order. Inasmuch as our October 30, 1990 order has now been affirmed, neither the Referee nor this Board has authority to alter it. Consequently, UEI is responsible for payment of the $4,300 attorney fee award.

ORDER

The Referee's order dated August 6, 1993 is affirmed.

In the Matter of the Compensation of
DIANNA L. GORDON, Claimant
WCB Case Nos. 92-03925 & 92-02723
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Pamela A. Schultz, Defense Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Pozzi Window (Pozzi), requests review of that portion of Referee Herman's order that set aside its partial denial of claimant's aggravation claim for a current right shoulder condition. Liberty, on behalf of Jake's Truck Stop (Jake's), argues that the Referee's order should be affirmed or, alternatively, that claimant's current condition is not compensable. On review, the issues are compensability and, if the claim is compensable, responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant first injured her right shoulder in a 1982 off-work sledding accident. In 1984, claimant sought treatment from Dr. Mann, osteopath, complaining of right shoulder pain since the sledding incident. (Ex. 26-3-2). Dr. Mann diagnosed chronic right shoulder tendonitis and disuse atrophy.

In the summer of 1988, claimant began working for Pozzi, performing tasks which required repetitive use of her right arm. She sought treatment for right shoulder pain in November 1988. Dr. Mann diagnosed diagnosed supraspinatus tendonitis.

Claimant filed a claim for a right shoulder injury, which Pozzi accepted as nondisabling.

Claimant stopped working for Pozzi in March 1989, for reasons unrelated to her employment. Her shoulder problems lessened thereafter.

In June 1989, claimant began waitressing at Jake's. The job required repetitive right shoulder use. Claimant sought treatment for her right shoulder and Dr. Mann's continuing diagnosis was tendonitis.

In early January 1990, claimant fell at home, striking her right shoulder against a door jamb. She sought emergency room treatment and missed 4 work days. X-rays were interpreted as "normal" at the time. Dr. Mann provided follow-up care and added acute bursitis secondary to right shoulder trauma to his continuing tendonitis diagnosis.

Claimant suffered flare-ups of right shoulder pain in April and December 1991. The December flare-up, associated with wood-gathering and dropping a kitchen drawer on the same day, was particularly significant. Dr. Knapp, Dr. Mann's colleague, diagnosed recurrent bicipital tendonitis and authorized a week off work.

In February 1992, Dr. Mann examined claimant and noted "gross crepitus" for the first time. Dr. Mann suspected right shoulder cuff disruption and referred claimant to Dr. Wigle, orthopedist.

Dr. Wigle examined claimant, diagnosed a right rotator cuff tear and recommended surgery, which was performed on March 31, 1992.

Pozzi issued a partial denial of claimant's right rotator cuff condition, on compensability and responsibility grounds.

Claimant filed a claim against Jake's, which Jake's denied on compensability and responsibility grounds.

FINDING OF ULTIMATE FACT

Claimant's off-work injuries were the major contributing cause of her torn right rotator cuff condition.

CONCLUSIONS OF LAW AND OPINION

Compensability/Pozzi

Pozzi accepted claimant's 1988 claim for a nondisabling right shoulder injury. (Ex. 3). Claimant did not challenge the nondisabling classification and she suffered no disability due to her right shoulder condition until 1990, over a year after claim acceptance. Thereafter, claimant timely perfected an aggravation claim against Pozzi, alleging that her work activities assembling screens caused her shoulder condition to worsen. (Exs. 11-8, 13-3).

The Referee did not apply ORS 656.273 to the claim for a worsened right shoulder condition, because the 1988 accepted injury claim was never closed. However, under the law in effect at the time of the 1988 injury, closure of a nondisabling injury claim was not required. See ORS 656.268; Webb v. SAIF, 83 Or App 386, 390 (1987); Stephanie L. Vollendroff, 42 Van Natta 945 (1990); see also Carolyn D. Fout, 42 Van Natta 2812 (1990) (Failure to close a nondisabling claim has no effect on claimant's aggravation rights). Accordingly, we apply the following analysis.

Claimant does not contend that her claim was initially misclassified nor does she contend that she did not receive notice from Pozzi that the injury had been initially classified as nondisabling. Moreover, her claim did not become disabling until more than a year after the date of injury. Accordingly, ORS 656.273 applies to the current claim for a worsened condition. See ORS 656.277(2); 656.273(4)(b); SM Motor Co. v. Mather, 117 Or App 176 (1992); Charles B. Tyler, 45 Van Natta 972 (1993). In addition, because the claim is denied on compensability and responsibility grounds, (Exs. 12, 17A; see Ex. 18), compensability is a threshold issue.

Pozzi's compensability denial asserts that claimant's right rotator cuff tear is not related to her accepted (1988) nondisabling injury. (Ex. 17A). At hearing, Pozzi supplemented its denial, arguing that off-work injuries were the major contributing cause of the torn rotator cuff condition. Thus, Pozzi's denial (as supplemented at hearing) challenges compensability on the ground that off-work injuries are the major contributing cause of claimant's current condition. See ORS 656.273(1).

Although a compensable worsening is generally established by the "material contributing cause" test, if an off-the-job injury or exposure is the major contributing cause of the worsened condition, the claim is not compensable under ORS 656.273(1). See Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992). In order to defeat an aggravation claim on this basis, after the claimant has established a material relationship between the compensable injury and the worsened condition, the insurer bears the burden of proving that the off-the-job injury or exposure is the major contributing cause of the worsened condition. See Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992); see also McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem, 111 Or App 666 (1992) ("Major contributing cause" means more than all other causes, explanations or exposures combined). Under these circumstances, assuming that claimant's condition is materially related to her accepted 1988 injury, we consider whether off-work injuries are its major contributing cause.

The medical evidence concerning causation is provided primarily by Dr. Mann, family physician, and Dr. Wigle, treating surgeon.

Before claimant's March 1992 surgery, Dr. Mann suspected that work activities at Pozzi were the most significant cause of claimant's right shoulder problems, based on her history. After the surgery, Dr. Mann deferred to Dr. Wigle regarding whether the torn rotator cuff resulted from acute or chronic processes. However, Dr. Mann also accurately noted that claimant's diagnosis did not change from "tendonitis" to "rotator cuff tear" until Dr. Wigle examined her in February 1992. (Exs. 26-21, 26-41-42)).

After a February 1992 arthrogram revealed a large defect in claimant's right rotator cuff, Dr. Wigle stated that he could not determine the age of the tear, particularly considering the chronicity of claimant's symptoms. (Ex. 20A). He acknowledged that Dr. Mann's chart notes revealed no "single one particular major incident" which would explain the tear and explained that he could not determine the "percent involvement" for each of the numerous incidents claimant described. (Id.; see Ex. 20AA-2).

After repairing a "rather massive disruption" of claimant's right rotator cuff, Dr. Wigle stated that its "exact cause" was unknown. (Ex. 20B-2; see Ex. 21). Dr. Wigle reported that claimant's massive tear involved "teres minor, as well as infraspinatus and supraspinatus," and found no evidence "of different stages of tear." (Ex. 20C). Further, based on the appearance of the tear, Dr. Wigle opined that a large single event was the cause, not "attrition." (Id.; see Ex. 26-43-44).

Considering claimant's relatively young age, Dr. Wigle was surprised at the size of the tear which he observed and repaired. (Ex. 23; see Ex. 25-3). Dr. Wigle eventually opined that claimant's "principal aggravation" occurred "while she was at work" at Pozzi.(Ex. 27).

However, considering Dr. Wigle's opinion as a whole, we conclude that the timing of claimant's symptoms was less significant to Dr. Wigle's conclusion than the appearance of the tear during surgery. Accordingly, we find Dr. Wigle's opinion (that the tear was caused by a large single event) consistent, well-reasoned and persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

The record does not reveal whether Dr. Wigle was apprised of claimant's numerous off-work injuries. (See Ex. 27). However, the distinguishing feature of claimant's work exposure at Pozzi was the absence of a discrete injurious event. Instead, claimant suffered an insidious onset and gradual worsening of symptoms, without a traumatic incident. On the other hand, claimant did suffer numerous off-work traumas to her right shoulder. Moreover, claimant recalled the December 1991 wood gathering and drawer dropping incidents as particularly painful. She stated, "I felt like a bear had gotten ahold of [my shoulder]. . ." (Tr. 46; see also Exs. 26-45, 26-68).

Considering Dr. Wigle's well-reasoned opinion, his "hands-on" advantage as claimant's treating surgeon, and the absence of a work-related trauma---in light of claimant's significant disabling off-work traumas---we conclude that Pozzi has established that the off-work injuries were the major contributing cause of claimant's torn rotator cuff. Consequently, Pozzi's partial denial must be upheld.

Compensability/Jake's

Claimant contends that her right shoulder condition is compensably related to her work exposure as a waitress at Jake's. However, inasmuch as Dr. Wigle's opinion establishes that claimant's condition results from a discrete injury and there was no such injury at Jake's (or at Pozzi), we conclude that the claim against Jake's is not compensable.

Responsibility

Because claimant's torn right rotator cuff condition is not compensable, there is no responsibility issue. However, as a final matter, we note that Pozzi remains responsible for claimant's initial right shoulder injury and the tendonitis condition which it accepted.

ORDER

The Referee's order dated April 19, 1993 is reversed in part and affirmed in part. Those portions of the order that set aside Liberty Northwest Insurance Corporation's partial denial, on behalf of Pozzi Window Company, and awarded claimant's counsel an assessed attorney fee are reversed. The partial denial is reinstated and upheld. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN W. HAMILTON, Claimant
WCB Case No. 92-14665
ORDER ON REVIEW
Max Rae, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Quillinan's order that dismissed claimant's hearing request as untimely filed. On review, the issue is the propriety of the Referee's order of dismissal. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of paragraphs four through six on page two of the order. We add the following modification and supplementation.

Between June and December, 1992, claimant rented a room at his brother Richard's home. Claimant received mail at Richard's home. Claimant was out of state on a long-haul trucking assignment between August 14, 1992 and September 12, 1992.

On August 25, 1992, the insurer issued a denial of claimant's injury claim. On August 27, 1992, the insurer issued a duplicate denial, because the first denial had been incorrectly addressed. Both denial letters were delivered by certified mail to Richard's home.

On August 27, 1992, Richard received and signed for the first denial letter. Richard told claimant about the denial and gave him the insurer's claims examiner's telephone number. On August 28, 1992, claimant called the claims examiner and told her that he had received the denial at home. The claims examiner explained the denial. Claimant agreed that he would call the claims examiner on September 4. Claimant did not call the claims examiner.

Richard received and signed for the correctly addressed duplicate denial letter on September 2, 1992.

Claimant returned to Richard's residence on September 12, 1992. Richard was in jail when claimant returned. Two or three days later, on either September 14 or 15, claimant discovered the two denial letters in Richard's room. Claimant continued to reside at Richard's home for the next three months.

On November 10, 1992, claimant filed his hearing request contesting the insurer's denials.

FINDINGS OF ULTIMATE FACT

On September 2, 1992, claimant constructively received the insurer's correctly addressed denial letter.

Claimant actually received the denial letter on either September 14 or 15, 1992.

Claimant did not file a request for hearing on the denial within 60 days after he received constructive knowledge of the denial.

Claimant has not established good cause for failing to timely file a request for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant received constructive notice of the insurer's denial letters on August 28 and September 2, 1992. The Referee further concluded that, because claimant had failed to establish that he had exercised reasonable diligence, claimant lacked good cause for failing to file his request for hearing within 60 days of his constructive notice. We agree that claimant's hearing request was untimely.

A request for hearing must be filed no later than the 60th day after a 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 denial confers jurisdiction if the claimant has good cause for the late filing. ORS 656.319(1)(b).

Notification occurs, and the 60-day and 180-day periods begin to run, when the claimant has either actual or constructive receipt of the denial. SAIF v. Edison, 117 Or App 455 (1992). A claimant is deemed to have constructive receipt of a denial if, unbeknownst to the claimant but on the claimant's behalf, a relative receives and signs for a certified, correctly addressed letter notifying the claimant of the denial. Anastacio L. Duran, Sr., 45 Van Natta 71, aff'd mem 124 Or App 678 (1993); James R. Barnett, 44 Van Natta 834 (1992).

We conclude that, on this record, claimant constructively received the insurer's denial on September 2, 1992. On that day, claimant's brother, Richard, received and signed the correctly addressed duplicate letter notifying claimant of the insurer's denial. Because claimant's residence was at Richard's home and because claimant received mail there, we conclude that Richard's receipt of the letter constructively put claimant on notice of the denial.

Claimant argues that, because he was on the road on a long-haul trucking assignment until September 12, 1992, and because his brother, Richard, was experiencing legal difficulties during August and September 1992, notifying Richard of the insurer's denial was not notice to claimant.[1] We disagree, because the focus of the analysis is on claimant's receipt of the denial through Richard, not on the personal circumstances of either claimant or Richard.

Because claimant constructively received the correctly addressed denial on September 2, 1992, the 60-day period under ORS 656.319(1)(a) began to run on that day and expired on November 1, 1992 (a Sunday). Because claimant filed his request for hearing on November 10, his request for hearing was untimely under ORS 656.319(1)(a). Therefore, for the request for hearing to be timely, claimant must prove good cause for failing to file within 60 days of constructive receipt of the denial. ORS 656.319(1)(b); SAIF v. Edison, supra.

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). Hempel v. SAIF, 100 Or App 68, 70 (1990); Anderson v. Publishers Paper Co., 78 Or App 513, rev den 301 Or 666 (1986). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234 (1984). Claimant has the burden of proving good cause. Id.

We conclude that, because of his lack of diligence, claimant has failed to establish good cause for failing to file a timely request for hearing. Claimant actually received the denial letter on September 14 or 15, 1992, six weeks before the expiration of the 60-day period. However, he did not contact an attorney until nearly two months later. There is no explanation in the record why claimant did not, at an earlier date, contact an attorney or request a hearing on his own. Moreover, the record reveals that claimant had actual knowledge, if not receipt, of the denial on August 28, 1992, and that he remained at his brother's home throughout the fall of 1992. Under these facts, we conclude that claimant failed to act with any diligence in protecting his legal rights. See Bertha Vega, 45 Van Natta 378 (1993); Cogswell v. SAIF, supra.

Finally, we note that, after claimant spoke to the insurer's claims examiner on August 28, 1992, claimant failed to follow up with his agreement to call the claims examiner on September 4 to discuss the denial further. We believe that claimant's failure to follow up with the claims examiner is further support for our conclusion that claimant did not act diligently. For these reasons, we conclude that claimant has failed to establish good cause for his untimely request for hearing.

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[1] On review, claimant argues that, because the insurer's denial letters did not comport with the precise requirements of OAR 438-05-055 (the letters say that the 60-day period runs from "the date of this letter," instead of from the date "you are notified of this denial"), his failure to file a timely request of hearing is excusable. We disagree. Claimant's failure to act for almost two months after he actually received the denial letters demonstrates that he did not rely on the denials' language.

Claimant argues that, under James R. Barnett, supra, and Giusti Wine Co. v. Adams, 102 Or App 329 (1990), because Richard failed to actually deliver the denial letters to him, he had good cause for failing to request a hearing within 60 days.[2] In response, the insurer argues that, because this case is analogous to Anastacio L. Duran, Sr., supra, we should hold that claimant has failed to establish good cause for failing to timely request a hearing. We disagree with both parties.

In light of SAIF v. Edison, supra, which holds that constructive or actual receipt of a denial will satisfy the notice requirement of ORS 656.319(1), Barnett, Giusti Wine Co. and Duran stand for the proposition that good cause exists where: (1) the claimant does not obtain actual receipt of a denial until more than 60 days after constructive receipt; and (2) the claimant was reasonably diligent in his or her attempt to become aware of the denial during the 60-day period. For the following reasons, we find that neither of those factors is present here.

First, as we explained earlier, claimant constructively received the insurer's denial on September 2, 1992 when his brother received the second, correctly addressed denial letter. Then, twelve or thirteen days later, claimant found that denial letter. Because claimant was in actual receipt of the denial well within the 60-day period, the first factor is not met. The second factor likewise is not met, because claimant's diligence in obtaining actual receipt of the insurer's denial within the 60 day period is not even in controversy. For these reasons, we conclude that Barnett, Giusti Wine Co. and Duran are not controlling.

In sum, claimant has failed to establish good cause for the untimely filing of his hearing request. Accordingly, we affirm the Referee's dismissal of this matter.

ORDER

The Referee's order dated June 3, 1993 is affirmed.

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[2] Claimant's argument under ORS 656.319(1)(b) improperly relies on the analytical scheme for ORS 656.319(1)(a). That is, he continues to argue that the 60-day period began to run on the day on which he was notified of his appeal rights, viz., the day that he found the denial letters.

In the Matter of the Compensation of
GOLDIE I. HOOD, Claimant
WCB Case No. 92-10786
ORDER ON REVIEW
Stunz, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Schultz's order that set aside its denial of claimant's aggravation claim for a current low back condition. Claimant cross-requests review, seeking an increased attorney fee award. On review, the issues are aggravation (compensability) and attorney fees.

We affirm and adopt the Referee's order, with the following supplementation regarding the attorney fee issue.

After completion of oral closing arguments, claimant submitted a statement of services to the Referee requesting a $2,450 fee. The statement describes approximately 22 hours of services associated with the hearing, including one and a half hours performed by a legal assistant.

The Referee awarded a $1,500 attorney fee.

On review, claimant requests an increased fee for services at the hearings level.

The insurer argues that the fee awarded by the Referee is adequate and reasonable. In support, the insurer asserts that workers' compensation attorney fees are contingent, not hourly, in nature.

We agree with the insurer that the Referee's fee award was reasonable. In reaching this conclusion, we note that the contingent nature of claimants' counsels' fees and the time spent on cases are but two of the factors considered in evaluating attorney fee requests.

Here, in determining a reasonable attorney fee, we consider the factors recited in OAR 438-15-010(4). Those factors are as follows: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (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.

Our review of the record reveals the following information. The file consists of 21 exhibits, including a deposition of claimant's treating physician. The latter involved 20 pages of questions and answers. Claimant's counsel generated one one-page letter from the treating physician. (See Ex. 20). The hearing took less than one hour and the transcript is only twelve pages long. Claimant was the only witness.

We draw the following conclusions from the forgoing findings and the fact that claimant prevailed against the insurer's denial of her aggravation claim. The issue in dispute was neither factually nor medically complex. The events which transpired at the hearings level (a hearing of less than one hour and one 20-page deposition) were fewer than usually involved in an aggravation claim. However, counsel did obtained benefits for claimant and there was a risk that counsel's efforts would go uncompensated.

Accordingly, 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. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). Claimant submits an additional statement of services and requests a $1,290 fee. ($3,740 for services at both levels less $2,450 for 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 fee for claimant's attorney's services on review concerning the compensability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, which is slightly more than 4 pages long, and counsel's statement of services), the minimal complexity of the issue, and the value of the interest involved. We further note that claimant's attorney is not entitled to a fee for services on Board review devoted to claimant's unsuccessful cross-request regarding the Referee's attorney fee award.

ORDER

The Referee's order dated March 29, 1993 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $750, payable by the insurer.

In the Matter of the Review of the Director's Order Concerning a Medical Services Dispute Regarding
DANNY S. JOHNS, Claimant
WCB Case No. 92-04996
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband, Hall, and Neidig.

The insurer requests review of that portion of Referee Hazelett's order that affirmed the Director's order under ORS 656.327(2) requiring reimbursement for chiropractic treatment. On review, the issue is whether the Director's order is supported by substantial evidence.

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

As a preliminary matter, contrary to the Referee's understanding, the insurer does not concede that the Director's findings are supported by substantial evidence.

On review, the insurer first contends that the Board's decision in Michael R. Sunseri, 43 Van Natta 663 (1991), was wrong, and therefore, the Referee's reliance on it was misplaced. The insurer argues that regardless of whether the chiropractic treatment given by Dr. Berovic was appropriate for the condition, the language of OAR 436-10-030(4) is mandatory, and therefore, strict compliance with the rule was required for the treatment to be reimbursable.

In order to conduct substantial evidence review, we must be able to determine what the Director found as fact, and why the Director believed that his findings reasonably led to the conclusions he reached. Armstrong v. Aston-Hill Co., 90 Or App 200 (1988). Here, the Director found that Dr. Goldberg's February 5, 1991 prescription (for continued chiropractic treatment by Dr. Berovic, three times per week for four weeks), did not include a statement of the treatment objectives. The Director also found that Dr. Goldberg's March 22, 1991 prescription (for two additional weeks of chiropractic treatment, three times per week), did not include a statement of the treatment objectives. Both of these findings are supported by substantial evidence. Nonetheless, the Director concluded that the treatment rendered by Dr. Berovic pursuant to the two prescriptions, was appropriate. The Director's order states that "[a]lthough treatment plans including treatment objectives were not submitted by Dr. Goldberg, the aspects of the modalities, frequency and duration were covered by his prescriptions of February 5, 1991 and March 22, 1991."

Although the Board's decision in Michael R. Sunseri, supra, was not specifically cited by the Director, the Director's decision is consistent with the Board's analysis and reasoning in Sunseri. The Board held, in Sunseri, that strict compliance with the written treatment plan requirement will not necessarily defeat compensability of the medical treatment if the treatment is shown by a preponderance of the evidence to have been reasonable and necessary.

The Board's decision in Sunseri did not issue under ORS 656.327. Rather, the Board exercised de novo review authority, whereas here, the Director had original jurisdiction of the medical services dispute, and the Board reviews the Director's order for substantial evidence. Despite the different procedural posture of the present case, we continue to find the Sunseri analysis correct.

Although appropriate medical services may be provided by a non-attending medical services provider, the attending physician is primarily responsible for determining the appropriate course of treatment to be administered for the compensable condition. OAR 436-10-005(1). Accordingly, the attending physician has the responsibility to supervise, in some cases control, and authorize treatment administered by non-attending medical services providers, such as the chiropractic treatments by Dr. Berovic in this case. (See OAR 436-10-030(4); -040(3); -041(3); -050). Submission of treatment plans signed by the attending physician is some indication that the attending physician's supervisory responsibility is being exercised. Nonetheless, we do not understand the Director to have intended, by the mandatory language of the administrative rule in question, to make the technical requirements for treatment plans more important than the appropriateness of the treatment provided. In other words, in a dispute over the appropriateness of the treatment, the appropriateness of the treatment remains the ultimate question.

In light of the above discussion, and in the absence of a specific form proscribed by the Director, OAR 436-10-040(3) does not present a situation where the Director should be compelled to put "form over substance." Furthermore, in interpreting and applying rules promulgated by the Director, the Director's interpretation is generally entitled to deference. Mershon v. Liberty Northwest Ins. Corp., 96 Or App 223, rev den 308 Or 315 (1989). Here, even absent a per se statement of treatment objectives, as found by the Director, the record as a whole supports a determination that adequate treatment objectives were present. In that regard, the ultimate findings by the Director are supported by substantial evidence.

Thus, we disagree with the insurer's argument that, as a matter of law, covered treatment is simply not reimbursable without "strict compliance" with the administrative rule, even if the treatment is appropriate for the compensable condition. We conclude that the extent of compliance is a factor to be considered with all of the medical evidence, to determine if the treatment was appropriate. Strict compliance with the treatment plan requirements would be a factor tending to show, that the attending physician has not simply acquiesced to the demands of the patient, or deferred unreasonably to the non-attending medical services provider, but instead, has approved the treatment based on the independent medical judgment. On the other hand, a failure to strictly comply with the treatment plan requirements may suggest that the treating physician is not fulfilling his supervisory responsibilities, and thus, his opinion is not entitled to the deference that it would otherwise be accorded.

Here, the Director concluded that the 19 chiropractor visits prescribed by Dr. Goldberg were appropriate treatment for claimant's compensable condition. In deferring to the treating doctor's judgment, the Director has decided that the failure of the treating doctor to strictly comply with the treatment plan requirements does not reflect on the doctor's part, any lack of attention to the medical needs, well being and treatment of his patient. There is ample evidence in the record upon which a reasonable person might reach that conclusion. We conclude that the order of the Director is supported by substantial evidence.

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 $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 August 20, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $700, to be paid by the insurer.

Chair Neidig dissenting:

Inasmuch as I am unable to conclude that the Director's order is supported by substantial evidence, I must respectfully dissent from the conclusion reached by my fellow members.

Where the attending physician has referred the injured worker to another physician for treatment, the Director has mandated that several prerequisites be satisfied before a carrier is obligated to reimburse the physician who provided the treatment. Those prerequisites are set forth in OAR 436-10-040(3)(a), which provides as follows:

> "Ancillary services including, but not limited to, physical therapy or occupational therapy by a medical service provider other than the attending physician shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and signed by the attending physician within 7 days of the beginning of treatment. The treatment plan shall include objectives, modalities, frequency of treatment and duration. A copy of the treatment plan shall be provided to the insurer by the attending physician within 14 days of the beginning of treatment." (Emphasis supplied).

Here, claimant's attending physician referred claimant to a chiropractor for a series of treatments. Those prescribed chiropractic services were subject to the treatment plan requirements of OAR 436-10-040(3)(a). See OAR 436-10-040(3)(b). When the insurer refused to reimburse claimant's chiropractor based on noncompliance with OAR 436-10-040(3)(a), Director review was requested.

After reviewing the dispute, the Director found that claimant's attending physician's prescription had satisfied the "modality, frequency, and duration" requirements of the aforementioned rule. The Director further acknowledged that the "objectives" requirement of the rule had not been submitted. Nevertheless, "based upon [the Medical Director's] review of the records," the Director concluded that the prescribed chiropractic treatment was appropriate.

In other words, despite recognizing that the mandatory prerequisites for obtaining reimbursement had not been satisfied, the Director still ordered the insurer to provide reimbursement. The majority concludes that substantial evidence supports the Director's findings, reasoning that deference should be given to the Director's interpretation and application of his own rules.

Were this simply a rule "interpretation" or "application" case, I would have no quarrel with my fellow members' reasoning. Likewise, had this case been litigated under a de novo review standard prior to the adoption of ORS 656.327(2), the propriety of the treatment could be established irrespective of compliance with the "written plan" requirements of OAR 436-10-040(3)(a). See Michael R. Sunseri, 43 Van Natta 663 (1991).

However, this case arises under the auspices of ORS 656.327(2) and, as such, our review is to determine whether the Director's order is supported by substantial evidence in the record. Moreover, the matter at issue does not involve the interpretation of a rule. To the contrary, the Director has conceded that the medical service provider has not satisfied the "objectives" requirement of the rule. Notwithstanding this acknowledged omission and without referring to any alternative point or authority, the Director still reaches the conclusion that the disputed services were appropriate and reimbursable.

Thus, the fundamental issue present in this case is whether the Director may arbitrarily choose not to require full compliance with his rules. My review of the Director's rules have failed to uncover a provision which grants the Director such discretion. In fact, a review of the Director's rules would suggest that they are binding.

First, the purpose of the medical services rules is to establish "uniform guidelines for administering the delivery of and payment for medical services . . ." OAR 436-10-002. Second, the rules are designed to carry out the provisions of ORS 656.327 (among other statutory provisions) and "govern all providers of medical services licensed or authorized to provide a product or service." OAR 436-10-003(1). Finally, the specific rule in question (OAR 436-10-040(3)) does not contain a provision that such written treatment plan requirements are merely "guidelines" or that the Director may choose to authorize reimbursement notwithstanding the failure to fully comply with the requirements. To the contrary, the rule is not only drafted in mandatory language ("shall"), but a later subsection provides that "[t]he preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service." See OAR 436-10-040(3)(e).

In light of such circumstances, I can reach no other conclusion than, in order to receive reimbursement for ancillary services, a medical service provider must establish that the "written treatment plan" requirements of OAR 436-10-040(3) have been satisfied.

Here, the Director did not find that the record as a whole supported a conclusion that written treatment "objectives" had been submitted by the attending physician in prescribing the chiropractic treatments. Had the Director made such a finding, I might have been inclined to conclude that there was substantial evidence in the record to support it. Instead, the Director expressly found that such "objectives" had not been submitted. Nevertheless, despite this acknowledged noncompliance with the written treatment plan requirement, the Director concluded that the prescribed chiropractic treatments were appropriate for the worker's condition.

As previously discussed, our review authority does not extend to whether the disputed medical services were appropriate. Rather, our review is confined to whether there is substantial evidence in the record to support the Director's finding that the services were appropriate. In conducting such an examination, we must utilize and apply the relevant administrative rules adopted by the Director to resolve such disputes.

The applicable rule provides that ancillary services shall not be reimbursed unless such services are carried out pursuant to a written treatment plan which includes "objectives." See OAR 436-10-040(3)(a). Despite finding that the "objectives" requirement had not been satisfied, the Director still concluded that the disputed services were reimbursable. In the face of unambiguous administrative prerequisites and in light of the Director's express acknowledgment of a provider's noncompliance with one of those prerequisites, I am unable to conclude that there is substantial evidence in the record to support the Director's finding that the services were appropriate and are reimbursable.

February 16, 1994 Cite as 46 Van Natta 281 (1994)

In the Matter of the Compensation of
DEBORAH J. LAYTON, Claimant
WCB Case No. 93-10036
ORDER OF DISMISSAL
Roberts, et al., Defense Attorneys

Claimant, pro se, has requested Board review of Referee McWilliams' December 16, 1993 order. We have reviewed the request to determine whether we have authority to consider the matter. Because the record does not establish that notice of the request was timely provided to the other parties, we dismiss.

FINDINGS OF FACT

On December 16, 1993, the Referee issued an Opinion and Order. On January 14, 1994, the Board received claimant's request for Board review of the Referee's order. The request, which was not mailed by certified or registered mail, did not indicate that copies of the request had been provided to the other parties.

On January 19, 1994, the Board mailed its 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 16, 1993 order was January 15, 1994, a Saturday. Consequently, the final day to perfect an appeal from the Referee's order was Tuesday, January 18, 1994 (Monday, January 17, 1994, was a holiday). Anita L. Clifton, 43 Van Natta 1921 (1991). Since claimant's request for review was received by the Board on January 14, 1994, it was timely filed.

Nevertheless, the record does not establish that the other parties to this proceeding 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). Specifically, claimant's request for Board review does not indicate that a copy of the request was provided to either the self-insured employer or its representatives. In fact, the record suggests that the other parties' first notice of claimant's appeal occurred when they received the Board's January 19, 1994 acknowledgment letter.

Inasmuch as January 19, 1994 is more than 30 days from the date of the Referee's December 16, 1994 order, we are persuaded that the other parties to this proceeding did not receive timely notice of claimant's request for Board review. Because the request is untimely, we lack authority to review the Referee's order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; 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. Moreover, 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.[1]

IT IS SO ORDERED.

[1] In the event that claimant can establish that she provided notice of her appeal to the other parties (the employer and its representatives) on or before January 18, 1994, she may submit such information for our review. However, to be considered, such information must be received in sufficient time to permit us to withdraw this order for reconsideration. Since our authority to reconsider this order expires within 30 days from the date of this order, claimant must respond in an expeditious manner.

February 16, 1994 Cite as 46 Van Natta 282 (1994)

In the Matter of the Compensation of
ELVA McBRIDE, Claimant
WCB Case No. 92-12747
ORDER ON REVIEW
Bryant, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Hall.

The self-insured employer requests review of Referee T. Lavere Johnson's order that set aside its denial of claimant's back injury claim. On review, the issue is whether the injury was within the course and scope of claimant's employment. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following modification and supplementation.

Claimant's June 10, 1992 trip to a bank in downtown Redmond involved a detour a few blocks from her normal route home.

FINDINGS OF ULTIMATE FACT

Claimant was a "traveling employee." Although on a personal errand at the time of her injury, she was not engaged in a distinct departure from her employment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's personal mission to a bank in downtown Redmond was a minor deviation from her work-related homeward trip to Bend. Noting that claimant had completed her personal banking business when she was injured, the Referee found that claimant's subsequent drive home must have been contemplated by the employer because the employer knew that claimant returned home every evening (as she was initially dispatched to jobsites from her home each morning). The Referee reasoned that claimant was in Redmond for the benefit of the employer on the day she was injured and that her regular on-the-job driving suggests that a motor vehicle accident (MVA) is a risk of claimant's employment. Thus, the Referee concluded that claimant established that her June 10, 1992 MVA occurred in the course and scope of her employment. We agree with the Referee's reasoning and conclusions, except where the Referee finds that claimant was not a "traveling employee."

Subsequent to the Referee's opinion, the Court of Appeals issued Proctor v. SAIF, 123 Or App 326 (1993), wherein the court addressed the compensability of an injury to a traveling employee. The court held that where travel is a part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of injury. Furthermore, employees whose work entails travel away from the employer's premises are within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Proctor v. SAIF, supra, citing 1A Larson, Workmen's Compensation Law 5-275, §25.00 (1990). Whether a traveling employee's injury occurred during a distinct departure on a personal errand depends on whether the activity that resulted in injury was reasonably related to the travel status. The test of a reasonable relation to the travel status is whether a claimant's presence at the place of injury had a work connection, or whether it violated employer directives or was so inconsistent with the purpose of the worker's trip, or such a deviation therefrom, as to constitute an abandonment of employment. Id.

Here, the first question is whether travel was a necessary incident of claimant's employment as a field engineer. We conclude that it was. Claimant's home is in Bend, Oregon. She was dispatched by the employer every morning by telephone from her home to various worksites in central Oregon. Claimant used her own car for work-related travel and received a car and mileage allowances in addition to wages. On this evidence, we conclude that claimant qualifies as a "traveling employee." See Proctor v. SAIF, supra; Rolland R. Duby, 45 Van Natta 2335 (1993).

The next question is whether claimant's June 10, 1992 trip from a bank at Sixth and Cascade Streets (in downtown Redmond) to approximately Sixth and West Evergreen Streets was a distinct departure from her employment on a personal errand. We conclude that it was not.

It is undisputed that claimant's trip to the bank was purely personal. However, that does not end the inquiry. For example, a personal errand associated with a worker's personal comfort needs is not a distinct departure from the worker's continuous coverage under the "traveling employee" rule. See Proctor v. SAIF, supra (Where a traveling employee was injured while playing basketball at a health club, thus satisfying his physical need for relaxation, the injury was compensable); PP&L v. Jacobson, 121 Or App 260 (1993) (Where a traveling employee was injured during his lunch break, the injury was compensable).[1]

Here, claimant had traveled to Redmond on a work assignmment, when she learned that the work order had been canceled and she was released for the rest of the day. Claimant stopped at a bank before traveling homeward to Bend, because she believed the banks in Bend would have been closed if she had driven home first. Thus, claimant's bank errand was for her personal convenience. There is no contention that claimant's belief or conduct was unreasonable, or that she disobeyed the employer in going to the Redmond bank. Under these circumstances, we conclude that claimant's personal bank errand in Redmond was reasonably related to her work status as a traveling employee. Because claimant was injured while returning to her homeward route after completing a personal convenience errand, we further conclude that the injury is 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 concerning the compensability issue is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 19, 1993 is affirmed. For services on review, claimant's counsel is awarded an $800 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
KATHY A. McCALL, Claimant
WCB Case No. 93-03239
ORDER ON REVIEW
Baxter, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Mills' order that: (1) declined to permit claimant an opportunity to present testimonial evidence from her former co-workers concerning the employer's past business practices; (2) found that the insurer had properly terminated claimant's temporary total disability benefits pursuant to ORS 656.268(3)(c); and (3) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable claim processing. Objecting to the Referee's evidentiary rulings and credibility findings, claimant seeks remand for a new hearing. On review, the issues are evidence, credibility, remand, temporary disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

After claimant was released to modified employment by her attending physician, the employer offered claimant modified employment in writing. Claimant began the modified employment but, the same day, she refused to work within the restrictions established by her physician. Thereafter, the insurer terminated claimant's temporary total disability benefits.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusion and Opinion" with the following supplementation regarding the Referee's evidentiary rulings and credibility findings, and claimant's request for remand.

EVIDENCE

On review, claimant argues that the Referee erred in refusing to allow her to present the testimony of three witnesses who would have testified regarding the employer's practice of placing injured workers in positions designed to cause them to be reinjured or to resign. Claimant argues that she was entitled to submit this evidence as proof of the employer's routine practices, ORS 40.180, or motive or plan in terminating claimant. ORS 40.170(3).

We need not resolve that question because even if claimant's "routine practice" evidence was admissible, we would find that the preponderance of persuasive evidence establishes that claimant refused to perform work within the limitations established by her physician. Accordingly, the Referee correctly concluded that the termination of claimant's temporary total disability benefits was justified under ORS 656.268(3)(c).

In her brief, claimant argues that the Referee prevented her from offering evidence to impeach the employer's witnesses by showing that those witnesses were untruthful because they were friends and had socialized together. Inasmuch as claimant did not raise that particular argument before the Referee, we are not inclined to consider it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).[1] Even if we considered that argument, however, inasmuch as the Referee has discretion as to whether to admit impeachment evidence, see OAR 438-07-017, Brian D. Lindstrom, 45 Van Natta 543 (1993), we would conclude that, on this record, the Referee did not abuse his discretion by not allowing claimant to offer evidence to impeach the employer's witnesses.

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[1] At the hearing, one of the employer's witnesses testified that, three years before the hearing, he had socialized with

CREDIBILITY

Claimant also urges us to reverse the Referee's credibility findings. Because those findings were based on the witnesses' demeanor and conduct at hearing, Humphrey v. SAIF, 58 Or App 360 (1982), and because claimant has offered no persuasive reason for reversing those findings, we do not disturb them. See Michele A. Montique, 45 Van Natta 1681 (1993).

REMAND

Inasmuch as our consideration of the excluded evidence would not alter the outcome of this dispute and since we find no reason to disturb the Referee's credibility findings, there is no compelling reason to remand this case to the Referee. We further find that the present record is neither improperly, incompletely nor otherwise insufficiently developed or heard by the Referee. See ORS 656.295(5). Accordingly, we reject claimant's request for remand.

ORDER

The Referee's order dated May 28, 1993 is affirmed.

February 16, 1994 Cite as 46 Van Natta 285 (1994)

In the Matter of the Compensation of
KELLY D. MUSTOE, Claimant
WCB Case No. 92-13386
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband, and Gunn.

The insurer requests review of Referee Livesley's order that increased claimant's scheduled permanent disability awards for a left and right forearm condition from 22 percent (33 degrees) for each forearm, as awarded by an Order on Reconsideration, to 42 percent (63 degrees) for each forearm. 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

Claimant has an accepted claim for bilateral carpal tunnel syndrome. A Notice of Closure awarded 14 percent scheduled permanent disability for each forearm. Those awards were increased to 22 percent scheduled permanent disability by the Order on Reconsideration.

At hearing, claimant asserted that he was entitled to additional permanent disability for loss of grip strength. The Referee agreed, awarding claimant 42 percent scheduled permanent disability for each forearm. The insurer challenges the increased award.

Loss of strength is rated when the cause is a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit. OAR 436-35-110(8); 436-35-110(8)(a) (WCD Admin. Rules 6-1992).

Claimant's treating physician, Dr. MacRitchie, first reported "a mild injury to the median nerves

Based on this evidence, we find that claimant's loss of strength was due only to pain and giveway weakness. Although Dr. MacRitchie first reported a mild injury to claimant's median nerves, it is not clear that Dr. MacRitchie was attributing the loss of strength to this condition. Furthermore, Dr. MacRitchie's subsequent report positively assigned causation to pain and giveway weakness. Therefore, because there is no evidence that claimant's loss of strength was caused by a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit, he is not entitled to a rating under OAR 436-35-110(8).

Claimant further asserts that, because his loss of grip strength is due to pain, he is entitled to a rating to the extent that pain has caused measurable impairment. He relies on OAR 436-35-010(3), which provides:

> "Pain is considered in these rules to the extent it results in objective measurable impairment. If there is no measurable impairment under these rules, no award of scheduled permanent partial disability is allowed."

We are not persuaded, however, that the rule supports an award in this case. On the contrary, we read the rule as being restrictive; it allows an award for pain only to the extent that pain causes "measurable impairment under these rules." In other words, an award is allowed for pain only when it causes impairment that is measurable under the standards. Our conclusion is supported by OAR 436-35-010(2), which provides:

> "Disability is rated on the permanent loss of use or function of a body part due to an on-the-job injury. These losses, as defined and used in these standards, shall be the sole criteria for the rating of permanent disability in the scheduled body parts under these rules." (Emphasis supplied.)

Thus, if a claimant's impairment due to pain cannot be measured under the standards, an award may not be given for pain. Turning to the facts of this case, we find that claimant's pain cannot be measured under the standards. As previously discussed, OAR 436-35-110(8) only allows a rating for loss of strength when the loss is caused by a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit. The rating allowed depends on which nerve is affected or impaired. The specificity of OAR 436-35-110(8), in contrast to the generality of OAR 436-35-010(3) which does not provide any impairment values and does not refer to any specific type of impairment, persuades us that OAR 436-35-110(8) exclusively governs whether a claimant is entitled to a rating for loss of grip strength.[1] Inasmuch as claimant has failed to prove a measurable impairment under OAR 436-35-110(8), he is not entitled to a rating for loss of grip strength.

We have the authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. See Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). Inasmuch as the standards already include a rule which addresses loss of grip strength, it is arguable whether this is an appropriate claim to remand to the Director for adoption of a temporary rule. However, we need not address that question because, inasmuch as claimant did not request the Director to adopt a temporary rule nor made a remand request either to the Referee at hearing or to the Board on review, we conclude that claimant did not preserve this issue for our review. See Brian G. Vogel, 46 Van Natta 225 (1994) (on reconsideration) (citing Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991)).

ORDER

The Referee's order dated February 10, 1993 is reversed.

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[1] We do not mean to imply that OAR 436-35-010(3) is superfluous. Unlike this case, there are instances where pain does result in measurable impairment under the standards. For example, a claimant who, because of chronic pain, is partially unable to repetitively use a body part is entitled to a permanent partial disability award for that "chronic condition." See Clifford J.

Board Member Gunn dissenting.

The majority correctly interpreted the medical evidence as showing that claimant has loss of grip strength due to pain and giveway weakness. I disagree, however, that claimant is not entitled to a rating for his loss of grip strength.

Under the standards, scheduled disability is "rated on the permanent loss of use or function of a body part due to an on-the-job injury." OAR 436-35-010(2). Furthermore, "[p]ain is considered in these rules to the extent it results in objective measurable impairment." OAR 436-35-010(3).

In finding that claimant is not entitled to a rating for loss of grip strength because he did not satisfy OAR 436-35-110(8), the majority ignores OAR 436-35-010(3), which explicitly provides for the consideration of pain when it results in objective measurable impairment. I interpret such language as indicating that a worker is entitled to a rating if there is proof of impairment due to pain.

Moreover, I would find that OAR 436-35-010(3) is applicable even though, like this case, there is a separate rule that addresses a particular type of impairment (i.e., grip strength loss). I find no suggestion in the standards supporting the majority's reasoning that, because there is a separate rule addressing a particular type of impairment, a worker is not entitled to a rating based on pain. Such an interpretation in effect voids OAR 436-35-010(3). Unlike the majority, I find no justification for taking such action in view of the fact that the standards do not indicate that OAR 436-35-110(8) exclusively governs the rating of impairment for grip strength and there is no argument that OAR 436-35-010(3) is statutorily or constitutionally defective. Furthermore, it does not carry out the legislature's objective of restoring the injured worker to a self-sufficient status to the greatest extent practicable. See ORS 656.012(2)(c).

Therefore, I would apply OAR 436-35-010(3) in conjunction with OAR 436-35-110(8). Here, claimant proved that he has loss of grip strength due to pain. Consequently, he is entitled to a rating.

Alternatively, I would find that claimant is entitled to the adoption of a temporary rule amending the standards to accommodate his impaired grip strength. See ORS 656.726(3)(f)(C). As I stated in my dissent in Gary D. Gallino, 44 Van Natta 2506 (1992), the Director is mandated to adopt a temporary rule to accommodate a worker's impairment when it is found that the worker's disability is not addressed by the standards. The Court of Appeals agreed, and reversed the Board's contrary holding in Gallino. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

Noting the Board's authority under ORS 656.295(5) to review the Director's application of the standards, the Gallino court held that the Board has the authority to determine whether a temporary rule is required to compensate a claimant for his disability. The court further held that, because only the Director can adopt a temporary rule, by necessary implication, the Board has the power to remand a case to the Director and must do so. Id.

According to his treating physician, claimant has proved impairment because he has loss of grip strength from pain. Therefore, if, as the majority finds, claimant is not entitled to a rating under OAR 436-35-010(3) or 436-35-110(8), his impairment is not addressed by the standards and the Director is required to adopt a temporary rule to address it. Accordingly, I would remand this case to the Director for the adoption of a temporary rule amending the standards to address claimant's bilateral grip strength loss due to pain.

In the Matter of the Compensation of
ROXANNE K. NEWPORT, Claimant
WCB Case No. 93-01156
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Hall, Westerband, and Neidig.

The self-insured employer requests review of those portions of Referee Howell's order that: (1) set aside the employer's denial of claimant's low back injury claim; and (2) assessed a 20 percent penalty for an allegedly unreasonable denial. In her brief, claimant requests that the Referee's penalty assessment be increased to 25 percent. On review, the issues are compensability and penalties.

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

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the employer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer 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).

The Referee held that the employer's January 8, 1993 denial constituted an unreasonable refusal to pay compensation because the employer did not have a legitimate doubt about its liability when it issued its denial. The Referee reasoned that the only information in the employer's possession when the denial was issued that cast doubt on the validity of the claim was claimant's vagueness regarding the date of her injury.

The employer contends that several other factors entered into its decision to deny the claim and that the denial was not unreasonable under the circumstances. The employer specifically cites claimant's six-day delay in reporting her injury and the fact that the injury was unwitnessed. Also, the employer's claims analyst had a verbal surveillance report which indicated that claimant was observed lifting and bending. She admitted, however, that she did not have a written report when the claim was denied. In addition, the analyst was aware of the employer's doubts regarding the validity of the claim because of claimant's initial vagueness regarding where and when the injury occurred. In this regard, we note that claimant called in sick for several days without reporting an injury and then told the employer that she "thought" she injured herself at work. Finally, the employer notes that it was unable to obtain a statement from claimant prior to issuing its denial.

The employer's arguments notwithstanding, we agree with the Referee that the denial was unreasonable. There is no indication that claimant had a preexisting low back condition. None of the doctors from whom claimant sought treatment before issuance of the denial questioned the validity of claimant's injury. The medical reports contained evidence of objective findings consisting of muscle spasm, tenderness and reduced range of motion. (Exs. 1, 3, 7). In addition, the record contains abundant evidence that the employer was largely motivated by its desire to issue a denial within 14 days to avoid paying interim compensation. (Ex. 10-3, Tr. 67, 68, 103, 104).

Moreover, the employer's claims analyst received knowledge of the claim on January 4, 1993, yet she issued the denial only 4 days later on January 8, 1993. (Tr. 97). While claimant initially refused to give a statement, claimant's attorney's office advised that it was willing to provide one after claimant had formally retained their services. (Tr. 68). Accordingly, the employer's initial inability to obtain a statement does not provide a legitimate basis for issuing its denial, particularly one issued within 4 days of the claim's receipt by the employer's claims analyst.

The employer had no indication that claimant may have hurt herself off-the-job. Claimant credibly testified that her delay in reporting her injury was due to her concern about her job since she had only been recently hired. (Tr. 14). The claims analyst never viewed the surveillance film or arranged an independent medical examination before issuing a denial. Significantly, the independent medical examination the employer ultimately obtained supported the compensability of claimant's low back injury claim. (Ex. 17-6). Dr. Neufeld stated the incident on December 20, 1992 was the material contributing cause of claimant's initial low back injury and need for treatment.

For the above reasons, we conclude that the employer did not have a legitimate doubt regarding its liability for claimant's claim when it issued its denial. In addition, after consideration of the record, we agree with the Referee's assessment of a 20 percent penalty.

Claimant is entitled to an assessed attorney fee for her counsel's efforts on review regarding the compensability issue. ORS 656.382(2). After considering all the factors in OAR 438-15-010(4), we find a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief and her counsel's statement of services), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services on review concerning the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated May 28, 1993 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

Board Chair Neidig dissenting.

The majority concludes that the employer's denial was unreasonable. I would find that the employer had legitimate doubt regarding its liability for this claim. I, therefore, dissent.

The majority affords great significance to the employer's claim's analyst having issued her denial only 4 days after receiving knowledge of the claim. However, they virtually ignore the legitimate reasons for issuance of the denial.

For instance, the alleged injury was unwitnessed and claimant worked for three days afterwards without complaint. Claimant never reported her injury to her employer until 6 days after it allegedly occurred. Moreover, claimant did not seek medical treatment until December 28, 1992, for an injury that allegedly occurred 8 days earlier. Although the medical records document that claimant had objective findings of injury, they merely establish the fact of injury. They in no way prove that claimant's injury occurred on the job, or, for that matter, how her injury happened.

Apart from these considerations, the employer's investigator informed the claim's analyst over the telephone that claimant had been observed lifting and bending. When one adds the employer's doubts regarding the validity of the claim because of claimant's vagueness as to the circumstances of the injury, there is only one conclusion that can be reached--the employer had legitimate doubt concerning its liability for this claim.

While I agree that based on this record claimant's low back injury is compensable, the majority's decision holds this employer (and future employers and insurers) to a stricter standard of "legitimate doubt" and "unreasonableness" than is warranted by the case law on which the majority relies.

Accordingly, I dissent.

In the Matter of the Compensation of
KEITH J. PRONDZINSKI, Claimant
WCB Case No. 92-16199
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employerr requests review of that portion of Referee Herman's order that set aside its partial denials of claimant's psychological condition. On review, the issue is compensability.

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

Claimant sustained a compensable low back injury in 1988 while employed as a carpentry instructor. Claimant was eventually released for modified work and received a total of 23 percent unscheduled permanent disability. Claimant continued to experience chronic pain, which resulted in his removal from work in February 1991.

In October 1991, claimant consulted a psychiatrist, Dr. Paulsen, in connection with a social security disability evaluation. Dr. Paulsen diagnosed dysthymic disorder. Claimant subsequently entered a pain center program during which a somatoform pain disorder was diagnosed along with associated features of depression. After an unsuccessful attempt at returning to work as a carpentry instructor, claimant was referred to a neurologist, Dr. Lafrance, who recommended psychological care.

Claimant returned to Dr. Paulsen in June 1992. Dr. Paulsen treated claimant ten times and diagnosed major depression, the major contributing cause of which was claimant's industrial injury. Dr. Larsen, an examining psychiatrist, evaluated claimant in September 1992 and diagnosed atypical depression and somatoform pain disorder, as well as a preexisting "mixed personality disorder." Dr. Larsen, who specializes in the treatment of alcohol and substance abuse, found claimant to be an alcoholic. He concluded that the major contributing cause of claimant's psychological condition was a combination of claimant's alcohol abuse and his preexisting personality disorder, not the industrial injury. Dr. Larsen's report prompted the employer to deny the compensability of claimant's psychological problems as well as his alleged alcoholism.

As the Referee noted, this claim is for benefits for the consequences of a compensable condition rather than an independent claim for occupational disease. Accordingly, claimant has the burden of proving that his compensable injury is the major contributing cause of his consequential psychological condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Although there is some medical evidence suggesting that claimant has a preexisting psychological condition, raising the possibility that ORS 656.005(7)(a)(B) is applicable, the legal standard under either provision is major contributing cause.

Both Dr. Larsen and Dr. Paulsen testified at hearing. The Referee found that Dr. Paulsen's opinion on the causation issue was more persuasive because she, as claimant's treating psychiatrist, was in the best clinical position to render an opinion on the causation of claimant's psychological condition. In addition, the Referee found it significant that, even assuming a preexisting personality disorder and alcoholism, these conditions had never required a need for treatment or disability before claimant's injury. The Referee discounted Dr. Larsen's opinion because of his nearly total disregard of the impact of claimant's injury on his need for psychological treatment

At the outset, the employer notes that the Referee failed to address the portion of its amended denial which denied the compensability of claimant's alcoholism. As claimant notes in his brief, the record supports a conclusion that he has not made a claim for treatment of alleged alcohol abuse. See Shannon M. Evans, 42 Van Natta 227 (1990). While the issue of claimant's alcohol abuse is relevant to a determination of the etiology of his psychological condition, no separate claim is being made for alcoholism. Therefore, we set aside that portion of the employer's denial which denied claimant's alcoholism as premature and only consider the compensability of claimant's psychological condition. Id.

The employer contends that the Referee erred in relying on Dr. Paulsen's medical opinion rather than Dr. Larsen's. It asserts that Dr. Larsen's credentials are far superior to Dr. Paulsen's in the area of alcohol abuse and that he provided the most well-reasoned and persuasive opinion. We disagree.

When the medical evidence is divided, we tend to give the greatest weight to the opinion of the treating doctor, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). We agree with the Referee, for the reasons mentioned in her order, that there are no such reasons in this case. In addition, we note that Dr. Lafrance also related claimant's psychological problems to his industrial injury. (Ex. 63-4). While Dr. Lafrance is not a psychiatrist, his opinion is entitled to some weight. See Barrett v. Coast Range Plywood, 294 Or 641, 649 (1983). Moreover, the psychologists at the Northwest Pain Center also reported a strong relationship between claimant's psychological condition and his compensable injury. (Exs. 49, 50). Therefore, Dr. Paulsen's opinion has support elsewhere in the record.

Dr. Larsen never provided a satisfactory explanation for his opinion when confronted with the fact that claimant had never previously experienced significant psychological difficulties even though his alleged personality disorder had preexisted his industrial injury for many years and his consumption of alcohol prior to his injury was at least equal to or greater than it was afterwards. (Tr. 171). Also, Dr. Larsen has no greater expertise in mood disorders than Dr. Paulsen. (Tr. 112, 133).

Finally, while Dr. Larsen opined that a preexisting personality disorder was an important factor in claimant's psychological condition, Dr. Paulsen disagreed with the diagnosis of a personality disorder. Significantly, personality disorder was not among those diagnoses given at the Northwest Pain Center. (Exs. 49, 50). Dr. Larsen conceded that the psychologists there had the expertise to detect such a condition and that the presence of a personality disorder would have been relevant to their assessment of claimant's psychological condition. (Tr. 164, 165, 166). In light of this, we do not find Dr. Larsen's medical opinion to be persuasive.

Accordingly, we agree with the Referee that claimant has carried his burden of proving a compensable psychological disorder. We, therefore, affirm the Referee's determination in this matter.

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 compensability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 2, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the self-insured employer.

February 16, 1994 Cite as 46 Van Natta 291 (1994)

In the Matter of the Compensation of
SHARON S. RAGER, Claimant
WCB Case No. 92-11069
ORDER ON REVIEW (REMANDING)
David C. Force, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Nielsen's order which dismissed her request for hearing concerning EBI Companies' refusal to pay medical billings for compensable treatment relating to her industrial injury. Claimant requests that this matter be remanded for a hearing. On review, the issues are dismissal and remand. We remand.

FINDINGS OF FACT

Claimant, who has an accepted injury claim with EBI, filed a request for hearing seeking payment of medical billings for treatment of her compensable back condition, as well as penalties and attorney fees. EBI responded that the billings were not timely submitted for payment and, therefore, were properly discounted under OAR 436-10-090(13). It appears from the record that claimant's private

health insurance carrier, Blue Cross of Oregon, made unspecified payments toward the disputed billings. Blue Cross has made a claim for medical service reimbursement from EBI.

Although a hearing was scheduled for November 17, 1992, the parties waived the hearing and agreed to submit the matter to the Referee based on stipulated facts and written closing arguments. However, due to a delay in the drafting of the stipulated facts, neither the stipulated facts nor closing arguments were submitted to the Referee. The Referee nevertheless issued her Opinion and Order dismissing the hearing request for lack of evidence that the billings were timely submitted to EBI for payment. In doing so, the Referee did not receive any evidence into the record. Indeed, the documents apparently considered by the Referee are not marked as exhibits.

CONCLUSIONS OF LAW AND OPINION

On review, claimant has submitted with her appellant's brief several documents, including an unsigned Stipulation of Facts. EBI does not object to our consideration of those documents. However, we find that those documents are insufficient for us to determine whether we have jurisdiction over this case.

The parties have not addressed whether the Board and its Hearings Division have subject matter jurisdiction over this dispute. Nevertheless, the jurisdiction issue may be addressed at any time in the course of litigation. See Schlect v. SAIF, 60 Or App 4490 (1982). Therefore, we address that issue here.

The jurisdiction of the Board and its Hearings Division is limited to "matters concerning a claim." ORS 656.708; see also ORS 656.283(1); ORS 656.289(3); ORS 656.295; Lloyd v. Employee Benefits Ins. Co., 96 Or App 591, 594 (1989); SAIF v. Zorich, 94 Or App 661, 664 (1989). ORS 656.704(3) provides, in relevant part:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly at issue." (Emphasis added.)

Hence, unless claimant's right to receive compensation is directly at issue, we lack jurisdiction of this dispute. The medical billings in dispute are for medical services that claimant has received for her back condition. EBI does not dispute claimant's right to receive any of those medical services. Rather, the dispute concerns the processing and payment of billings for compensable medical treatment.

There is evidence in the file that claimant's private health insurance carrier, Blue Cross, made unspecified payments toward the disputed billings and has a pending claim for medical service reimbursement from EBI. Although claimant alleges that she also made payments toward those billings, there is no evidence in the record that claimant has submitted a claim for medical service reimbursement from EBI.

The court has previously held that medical service reimbursement from one carrier to another is not "compensation" within the meaning of ORS 656.005(8). Lloyd v. Employee Benefits Co., supra. Therefore, if the sole issue in this case concerns whether EBI must fully reimburse Blue Cross for its expenditures to claimant's medical service providers, we lack jurisdiction of this dispute. In other words, a condition precedent to our asserting jurisdiction in this case is that claimant seek reimbursement from EBI for medical service payments made by claimant.

We may remand a case to the Referee if we find that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Inasmuch as there is no "record" and the evidence in the file is insufficient for us to determine our jurisdiction over this case, we conclude that this case was insufficiently developed by the Referee.

Accordingly, the Referee's order dated December 31, 1992, as reconsidered February 12, 1993, is vacated. The matter is remanded to the Presiding Referee for assignment to a referee with instructions to admit evidence and/or argument from both parties pertaining to the jurisdiction issue. If the assigned

referee determines that the Hearings Division has jurisdiction over this matter, the referee shall admit evidence pertaining to the merits of the claim processing, penalty and attorney fee issues. The additional evidence may be presented in any manner the referee determines achieves substantial justice. Following the presentation of the evidence and the closure of the record, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

February 16, 1994 Cite as 46 Van Natta 293 (1994)

In the Matter of the Compensation of
SHERRY L. ROSE, Claimant
WCB Case No. 92-11663
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order that: (1) found that claimant was not precluded from litigating her claim for right elbow and wrist entrapment; and (2) set aside its denial of claimant's claim for the same condition. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's current right elbow and wrist condition is not the same as any of the specific conditions that SAIF denied in 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current condition, diagnosed as both right elbow and wrist entrapment and right ulnar and median neuropathy, (see Exs. 6-5, -6; 8-1), is not the same as any of the conditions that SAIF denied in 1991, viz., possible thoracic outlet syndrome, right rotator cuff tendonitis and right lateral epicondylitis. SAIF argues that, because claimant's current symptoms are similar to those she experienced in 1991, she has failed to establish that the two conditions are different. We disagree.

An uncontested denial bars future litigation of the denied condition, unless the denied condition has changed. Mary H. Morris, 44 Van Natta 1273 (1992). This bar does not, however, prevent a claimant from litigating a condition that is different than the denied condition. Margaret R. Jones, 45 Van Natta 1249 (1993).

If a carrier denies a specific condition, and the claimant does not contest the denial, to determine whether the uncontested denial will preclude the claimant from litigating her current condition, we review the medical evidence to ascertain whether the claimant's current condition is something other than that specific condition. See Mary H. Morris, supra; see also Georgia Pacific v. Piwowar, 305 Or 494 (1988) (The employer could not deny a specific back condition, ankylosing spondylitis, after it had accepted a claim for sore back). Therefore, if the two conditions are different, claimant is not precluded from litigating her current condition.

Here, SAIF's 1991 denial letter characterized claimant's condition as "an occupational disease described as possible thoracic outlet syndrome, rotator cuff tendonitis, right and right lateral epicondylitis." (Ex. 4-1.) Because SAIF denied three specific conditions, claimant is barred from litigating her current condition only if it is the same as any of the three denied conditions. It is not.

Claimant's current condition was diagnosed as right elbow and wrist entrapment, (Exs. 6-6, 8-1), or possible ulnar and median neuropathy. (Ex. 6-5). Both claimant's attending physician and SAIF's medical examiner considered claimant's current diagnosis as something other than any of her earlier conditions. (See Exs. 12-2, 13-18). Accordingly, we find that claimant's current condition is different from any of those that SAIF denied in 1991. For this reason, we affirm the Referee's conclusion that claimant is not barred from litigating her current condition.

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 assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the 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 27, 1993 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
KRISTY R. SCHULTZ, Claimant
WCB Case No. 92-15832
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Bethlahmy's order that reduced claimant's unscheduled permanent partial disability (PPD) award from 6 percent (19.2 degrees) to zero. The self-insured employer cross-requests review of that portion of the Referee's order that found that the Department of Insurance and Finance (DIF)[1] lacked jurisdiction to issue an amended Order on Reconsideration that reduced claimant's unscheduled PPD award from 6 percent (19.2 degrees) to zero. On review, the issues are the Referee's authority to reduce claimant's PPD award, extent of unscheduled permanent disability and, alternatively, DIF's jurisdiction to issue the amended Order on Reconsideration. We affirm.

FINDINGS OF FACT

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

Drs. Ayers, Burr and Watson ("the arbiter panel") found that, on active range of motion, by inclinometer, claimant's maximum lumbar flexion was 52 degrees; extension, 14 degrees; right lateral flexion, 26 degrees; and left lateral flexion, 24 degrees. (Ex. 98-3.)

CONCLUSIONS OF LAW AND OPINION

The employer argues that because, at hearing, it orally requested that claimant's PPD award be reduced to zero, and because claimant did not object to that request, the Referee had authority to reduce the PPD award. It refers us to Salter v. SAIF, 108 Or App 717 (1991) as support for that argument. We agree.

In Salter, a noncomplying employer filed a Request for Hearing regarding an order of noncompliance. At the hearing, the employer orally raised the issue of compensability and the issue was tried to the referee without objection. On appeal, the SAIF Corporation argued that, because the employer had not filed a written Request of Hearing as required by ORS 656.283(3), the matter was not properly before the referee. The Court of Appeals rejected that argument, concluding that, although compensability of the claimant's injury had not been raised before the hearing, because the requirements of ORS 656.283(3) are not jurisdictional, and because the question of compensability was orally raised at the hearing, without objection, the issue was properly before the referee. Id. at 720.

Salter controls this case. Ordinarily, to challenge the determination of the extent of claimant's PPD, the employer must file a Request for Hearing pursuant to ORS 656.283(3). However, here, as in Salter, the employer orally requested a reduction in claimant's PPD award at the hearing. (Tr. 7-8.) Claimant did not object to the employer's request, and the issue was tried to the Referee. (See Tr. 8). Under these circumstances, the issue was properly before the Referee. Accordingly, we conclude that the Referee had authority to reduce claimant's PPD award.[2]

In reaching this conclusion, we note the cases that have held that, when a claimant's request for hearing puts a permanent disability award at issue, the carrier is not barred from requesting a reduction of the award even though it did not request a hearing to challenge the award. Pacific Trucking Co. v. Yeager, 64 Or App 28 (1983); Gleason W. Rippey, 36 Van Natta 778 (1984). The rationale for this proposition is simple: When a claimant appeals the extent of an award of permanent disability, the claimant opens the extent issue completely so that the referee may either affirm, increase or decrease the award. Gleason W. Rippey, supra, 36 Van Natta at 779 (quoting Lesley L. Robbins, 31 Van Natta 208 (1981)).

Here, claimant did not withdraw her request for hearing, which included the extent of permanent partial disability. Accordingly, the employer was entitled to raise, and the Referee properly could consider, any issues pertaining to the extent of claimant's permanent disability.

Extent Of Unscheduled Permanent Disability

The Referee concluded that because the arbiter panel found multiple inconsistencies in, and no objective basis for, claimant's symptoms, claimant had failed to establish any permanent impairment. Claimant argues that both her treating physician's opinions and the arbiter panel's findings of decreased lumbar range of motion establish an objective basis for a permanent disability award. We disagree.

Impairment is established by a preponderance of the medical evidence based on objective findings. ORS 656.726(3)(f)(B). The level of the claimant's impairment is determined by her attending physician, unless a preponderance of the medical evidence establishes a different level of impairment. OAR 436-35-007(9); Debra L. Godell, 45 Van Natta 34 (1993).

Here, DIF awarded claimant unscheduled permanent partial disability related to her decreased lumbar range of motion. (See Exs. 96, 99). Claimant's treating physician, Dr. Manley, did not evaluate claimant's lumbar flexibility. (See Ex. 97B-2). Accordingly, his opinion is of no assistance in evaluating claimant's impairment.

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[2] In any event, claimant's argument regarding the Referee's authority to reduce her PPD award is not well-taken. Our rules provide that requests for hearing may be freely amended up to and at the time of hearing. See OAR 438-06-031; Lloyd L. Crockett, 43 Van Natta 1767, order den repub, 43 Van Natta 1923 (1991). If the nonmoving party claims surprise or prejudice by a proposed amendment, that party may request continuance. See OAR 438-06-031. Here, claimant neither professed surprise or prejudice, nor requested a continuance.

Claimant argues that, because the arbiter panel found that she had some impairment of her lumbar range of motion as measured by an inclinometer, pursuant to former OAR 436-35-360(19), (20) and (21), she has an impairment rating of 6 percent. (See Ex. 99). We disagree.

The arbiter panel found that claimant had some diminished lumbar flexibility on active range of motion and that there was no objective basis for claimant's subjective complaints. (Ex. 98-3, -4). It also found multiple inconsistencies in claimant's examination, and overt non-physiologic pain behavior, indicative of probable malingering. (Id). Finally, it noted that claimant's x-rays taken four days after her December 1990 work injury demonstrated a preexisting degenerative condition at L4-5 and L5-S1. (Id. at 5). For these reasons, the panel evidently concluded that claimant's decreased lumbar range of motion did not reflect any corresponding permanent impairment caused by her December 1990 compensable injury. See Lydia L. Kent, 44 Van Natta 2438 (1992).

We are persuaded by the arbiter panel's reasoning and conclusion. The inconsistencies in claimant's examination and her overt pain behavior raise an inference that her range of motion findings were invalid. See Iuel L. Fadness, 43 Van Natta 520 (1991). This inference is supported by a medical report that states that claimant had voluntarily restricted her motions during a February 1991 examination regarding an unrelated shoulder injury. (Ex. 24-5, -7.) See Patsy R. Butterfield, 45 Van Natta 1096 (1993).[3]

On this record, we are not persuaded that claimant's lumbar range of motion findings are sufficient objective evidence of impairment. Accordingly, we conclude that the Referee properly reduced claimant's unscheduled PPD award from 6 percent to zero.

Because we have reached this conclusion, we need not consider whether DIF had jurisdiction to issue the amended Order on Reconsideration that reduced claimant's unscheduled PPD award from 6 percent to zero.

ORDER

The Referee's order dated April 13, 1993 is affirmed.

[3] The opinions of claimant's treating physician also support this inference. Dr. Manley concurred with Drs. Phipps and Waldram's independent medical examination report, which demonstrated multiple inconsistencies in claimant's complaints, inconsistent range of motion, and found no objective impairment. (Exs. 48, 47-4). Thereafter, Manley agreed that claimant's emotional behavior usually outweighed any physical findings of impairment. (Exs. 89-1, 92-3).

In the Matter of the Compensation of
DANIEL L. WALLACE, Claimant
WCB Case No. 91-18371
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of those portion of Referee Nielsen's order that: (1) upheld the insurer's partial denial of his claim for inflammatory spondyloarthropathy; and (2) declined to assess a penalty-related attorney fee for an alleged discovery violation. On review, the issues are compensability and attorney fees.

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

On review, claimant argues that a prior stipulated order awarding him additional permanent disability benefits for his compensable injury was an acceptance of the inflammatory spondyloarthropathy, as a matter of law. We disagree.

We begin with a summary of the relevant facts. Claimant compensably injured his low back in an on-the-job auto accident on August 5, 1986. The claim was accepted for a low back "contusion" and later closed by Determination Order on December 29, 1986 with no permanent disability award. (Exs. 2, 5).

Claimant continued treating for low back pain. In September 1987, claimant was complaining of intermittent pain and tingling in both legs. (Ex. 8). An October 1987 myelogram and CT scan revealed a bulging lumbar disc. (Ex. 7). The claim was reopened for an aggravation. In May 1989 Dr. Karasek opined that claimant has permanent disability based on intermittent low back pain with reduced ranges of motion. (Ex. 15).

The claim was closed by Determination Order on April 19, 1990 with an award of 17 percent unscheduled permanent disability. (Ex. 19-1). The Department's evaluation worksheet shows that the permanent disability award was based on findings of lost range of motion and a bulging disc. (Ex. 19-2). By Stipulated Order dated October 15, 1990, claimant's unscheduled permanent disability award was increased to 30 percent. (Ex. 20). The parties stipulated that the "additional award anticipates that claimant will experience periodic symptomatic flare-ups in his condition." (Ex. 20-2).

Claimant continued to treat for low back pain. In July 1991 claimant developed severe low back and right leg pain. Over the next few months claimant also developed intermittent left leg pain. In December 1991, after undergoing a series of diagnostic studies, claimant was examined by Dr. Rosenbaum, who diagnosed inflammatory spondyloarthropathy as the chief cause of claimant's then-current symptoms. (Ex. 30-5). This was the first diagnosis of inflammatory spondyloarthropathy. Dr. Rosenbaum explained that the diagnosis is consistent with the waxing and waning severity of claimant's discomfort. He opined that the compensable injury is not the cause of the symptoms. (Ex. 30-6).

On February 21, 1992, the insurer denied claimant's claim for spondyloarthropathy. (Ex. 43).

In March 1992 rheumatologist Dr. Becker diagnosed spondyloarthropathy and opined that, although the compensable injury may be a minor factor in claimant's symptoms, the spondyloarthropathy is the major factor. (Ex. 45). In May 1992 Dr. Hacker diagnosed claimant's condition as a combination of spondylotic arthropathy and disc injury. He opined that the compensable injury accounted for a significant portion of claimant's treatment over the past few years, but that the spondylotic arthropathy will probably represent the majority of claimant's condition over the long term. (Ex. 45A).

In July 1992 rheumatologist Dr. Maier concurred with claimant's counsel's letter which stated that claimant has had ankylosing spondylitis (also called spondyloarthropathy) for several years. (Ex. 52). The letter also stated that the disease can be asymptomatic, but if it is symptomatic, it has probably been causing pain for the previous two years or more. (Id).

Claimant contends that, by stipulating to the additional permanent disability award for anticipated future "symptomatic flare-ups" in October 1990, the insurer accepted the condition ultimately diagnosed as spondyloarthropathy. Claimant relies on SAIF v. Forrest, 68 Or App 312 (1984). However, we find that Forrest is distinguishable on its facts.

In Forrest, the claimant injured his knee on the job. His claim was accepted and closed with a 10 percent scheduled permanent disability award. Subsequently, a referee increased the award based on the finding that the compensable injury resulted in a loss of knee extension. The referee's order was not appealed. Thereafter, the claimant had surgery to regain the knee extension. As a result of the surgery, it was determined that the loss of extension was due to a nonindustrial accident preceding the compensable injury. The carrier then denied the surgery as unrelated to the compensable injury. The court held that, because the referee had previously found that the claimant's loss of extension was a compensable disability, and that finding was not appealed, the surgery to correct that disability could not be denied by the carrier. Id. at 316.

Here, claimant has not established by a preponderance of the evidence that the stipulated award of permanent disability in October 1990 was based on symptoms of the spondyloarthropathy that was eventually diagnosed in December 1991. The stipulation itself does not explain the basis for the award,

except for the anticipation of future symptomatic flare-ups. Further, the medical evidence does not show that the flare-ups anticipated were for spondyloarthropathy. At most, the medical evidence shows that claimant probably had spondyloarthropathy at the time of the stipulation. However, there is no persuasive medical evidence that the spondyloarthropathy was symptomatic and disabling at the time of the stipulated award. Finally, all of the doctors diagnosing spondyloarthropathy saw claimant after the stipulation. Therefore, their opinions concerning the cause of symptoms claimant had at the time of the stipulation are suspect, and we do not rely on them.

Inasmuch as we do not find that claimant's stipulated permanent disability award was based on disabling symptoms of spondyloarthropathy, Forrest does not preclude the insurer's denial of that condition. The insurer's denial is upheld. Finally, because claimant has not established his entitlement to compensation for the denied conditions, we do not find that the insurer unreasonable resisted the payment of compensation. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599, 605 (1991). Accordingly, no penalty-related attorney fee may be assessed under ORS 656.382(1).

ORDER

The Referee's order dated May 5, 1993 is affirmed.

February 17, 1994 Cite as 46 Van Natta 298 (1994)

In the Matter of the Compensation of
SUSIE A. FIMBRES, Claimant
WCB Case No. 90-16803
ORDER ON REMAND
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). The court reversed our prior order, Susie A. Fimbres, 43 Van Natta 2289 (1992), on recon 44 Van Natta 1121 (1992), which had upheld the insurer's "back-up" denial of claimant's cervical spondylosis condition. Applying ORS 656.262(6), we reasoned that the insurer was entitled to revoke its previous acceptance of claimant's cervical condition made pursuant to a prior stipulation that had dismissed claimant's request for hearing from the insurer's denial of that condition. Reasoning that the stipulation (which was approved by a referee) had the finality and effect of a judgment, the court concluded that the agreement was not an "acceptance" and that ORS 656.262(6) could not and should not apply. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in our October 8, 1991 Order on Review.

ULTIMATE FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer's denial was an improper "back-up" denial and therefore should be set aside. In our October 8, 1991 Order on Review, we agreed that the denial should be set aside, however we did so on a different basis. Specifically, we found that the insurer's denial was barred based on the the res judicata doctrine of issue preclusion. Susie A. Fimbres, 43 Van Natta 2289 (1991). However, on reconsideration, we concluded that the insurer's denial was proper under ORS 656.262(6) and found on the merits that the insurer had established by clear and convincing evidence that claimant's current cervical condition was not compensable. Susie A. Fimbres, on recon 44 Van Natta 1730 (1992). We therefore upheld the insurer's denial.

As noted above, the court has reversed our Order on Reconsideration finding that ORS 656.262(6) did not apply. Consequently, the court has remanded for reconsideration.

On reconsideration, we adhere to our initial holding that the insurer is precluded from denying claimant's cervical spondylosis based on the following reasoning.

In February 1989, Dr. Corson informed the insurer that claimant's symptoms were due to cervical spondylosis. Dr. Corson made no other diagnosis for claimant's condition. On March 7, 1989, the insurer denied claimant's then-current condition which it indicated was cervical spondylosis, on the basis that it was unrelated to her compensable injury.

Claimant requested a hearing on this denial. On March 7, 1990, the insurer amended its denial to deny only responsibility for claimant's cervical condition. On June 20, 1990, the parties entered in to a stipulation and settlement in which the insurer agreed to rescind its denial and reopen claimant's claim in exchange for claimant dismissing her hearing request.

At the time of the June 20, 1990 stipulation, Dr. Corson, Dr. Purtzer and the Medical Consultants all indicated that claimant's symptoms were due to her degenerative cervical spondylosis. (Exs. 47, 49, 51, 52). Therefore, the record establishes that claimant's current cervical condition is the same condition that she had at the time of the June 20, 1990 stipulation, when the insurer's March 7, 1989 and March 7, 1990 denials were rescinded. Thus, under the doctrine of issue preclusion, the June 20, 1990 stipulation establishes as a matter of law that claimant's cervical spondylosis is compensably related to her 1987 industrial injury. In other words, the connection between claimant's cervical spondylosis and the work injury was determined by a valid final judgment when the parties entered into the stipulation which rescinded the insurer's prior denials. See Eileen A. Edge, 45 Van Natta 2051 (1993).

Therefore, the insurer is precluded from denying claimant's cervical spondylosis on the basis that it is unrelated to the industrial injury. Inasmuch as the insurer's November 9, 1990 denial denies claimant's cervical spondylosis on that basis, it must be set aside under the res judicata doctrine of issue preclusion. See International Paper Company v. Pearson, 106 Or App 121 (1991); Eileen A. Edge, supra.

Accordingly, on reconsideration, we set aside the insurer's denial. The claim is remanded to the insurer for processing in accordance with law.

IT IS SO ORDERED.

February 17, 1994 Cite as 46 Van Natta 299 (1994)

In the Matter of the Compensation of
MARILYN M. GUARDIPEE, Claimant
WCB Case No. 92-15907
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nichols' order that affirmed a Director's order that found that claimant was not eligible for vocational assistance. On review, the issue is vocational assistance. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right elbow. The insurer found claimant ineligible for vocational assistance on the basis that she possessed the necessary skills and abilities to return to a job that paid a wage within 20 percent of that of her regular work. Claimant requested review by the Director. The Director's order found that claimant was capable of light work and that there existed in substantial numbers work within claimant's physical abilities and training. Therefore, the Director concluded that claimant did not have a substantial handicap to employment and was not eligible for vocational assistance.

The Referee found support in the record for the Director's determinations that claimant retained sufficient physical capabilities and training to perform certain modified light duty activities. Therefore, the Referee affirmed the Director's order.

In reviewing the Director's order, the Referee relied on the Court of Appeals' decision in Colclasure v. Washington County School Dist. No. 48-J, 117 Or App 128 (1992). In that case, the court construed ORS 656.283(2) as providing that a Director's order concerning the eligibility of vocational services could not be modified if the Referee or Board factual findings differed from those of the Director.

Subsequent to the Referee's order, the Supreme Court reversed the Court of Appeals' decision. In Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993), the Court held that the proper procedure for review of vocational assistance decisions constituted, first, an informal investigation and issuance of an order by the Director; then a hearing before a Referee during which a record was developed; development of factual findings by the Referee based on the record and a conclusion as to whether the Director's order survived review; and, finally, review by the Board under ORS 656.283(2) upon the record developed before the Referee. Id. at 537.

In this case, the procedure conducted before the Referee comported with this process. The parties developed a record at hearing, which included testimony by vocational assistance experts as well as documentary evidence regarding claimant's physical capabilities. On the basis of the record, the Referee found that claimant was physically able to perform certain jobs. Based upon those findings, the Referee concluded that the Director did not abuse his discretion in finding claimant ineligible for vocational services. Consequently, having found that the proceedings below complied with Colclasure, we undertake review under ORS 656.283(2) of the record developed at hearing.

At hearing, based on the testimony of Byron McNaught, claimant asserted that she was incapable of performing any work without vocational assistance. In particular, claimant contended that her lack of training limited her to entry-level work and that she was significantly limited in "reaching" and "handling", abilities demanded by all entry-level jobs. (Tr. 32-34). That testimony was contradicted by Suzanne Blackorby, a vocational consultant for the Workers' Compensation Division, who testified that claimant was capable of performing certain entry-level work that required no training, such as small parts assembling, cashiering, and general office clerk. (Id. at 24-26). Ms. Blackorby based her opinion on her understanding that claimant was restricted from lifting over 15 pounds, but could perform repetitive simple grasping and fine manipulation. (Id. at 17-18).

We find that Ms. Blackorby based her opinion on a more accurate knowledge of claimant's physical restrictions. Claimant's treating orthopedic surgeon, Dr. Stevens, concurred with the report from an examination conducted on behalf of the insurer restricting claimant to lifting 15 to 20 pounds on an occasional basis and 10 pounds on a regular basis. (Exs. 8-4, 11). That examining panel also recommended against heavy repetitive pushing and pulling. (Ex. 8-4).

After performing a physical capacities examination, Dr. Stevens provided the same lifting restrictions. (Exs. 10, 12). Dr. Stevens also indicated that claimant could repetitively perform simple grasping and fine manipulation. (Ex. 10). However, he restricted claimant from repetitive reaching and pushing with her right arm and repetitive squeezing, gripping and pronated lifting. (Exs. 12, 15).

A subsequent form 828 containing Dr. Stevens' stamped signature indicated that claimant was restricted from pushing, pulling and lifting. (Ex. 17). However, in view of Dr. Stevens' prior reports, we interpret the form as merely indicating that claimant was restricted from repetitively pushing, pulling and lifting.

Having found that Ms. Blackorby based her opinion on an accurate understanding of claimant's physical restrictions, we find that it is more reliable with regard to claimant's abilities to perform certain entry-level work requiring no training. Furthermore, according to Ms. Blackorby, such work paid a wage within 20 percent of that earned from claimant's regular work. (Tr. 16). Thus, we agree with the Referee that there was no abuse of discretion by the Director in finding that claimant did not have a substantial handicap to employment and, therefore, was not eligible for vocational assistance.

ORDER

The Referee's order dated March 16, 1993 is affirmed.

In the Matter of the Compensation of
JEROME D. McINTYRE, Claimant
WCB Case No. 92-13846
ORDER ON REVIEW
Dennis Messoline, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Referee Mongrain's order that found that claimant's injury occurred in the course and scope of his employment. In addition, SAIF moves to strike claimant's "Respondent's Reply Brief". On review, the issues are motion to strike and course and scope. We grant the motion, and affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Amended Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

SAIF filed an appellant's brief, followed by claimant's respondent's brief, and SAIF's reply brief. Thereafter, claimant submitted a document entitled "Respondent's Reply Brief." SAIF has moved to strike claimant's submission on the ground that no such brief is authorized under the administrative rules. We agree.

OAR 438-11-020(2) authorizes the filing of: an appellant's brief, a respondent's brief, a cross-appellant's brief, a reply to a respondent's brief, and a cross-reply brief. There is no provision for a respondent to file a reply brief.

Accordingly, we grant SAIF's motion, and do not consider claimant's "Respondent's Reply Brief" in our review.

Course and Scope of Employment

On review, SAIF renews its contention that claimant was injured prior to arriving at his "work station." Therefore, it argues, the Referee should have applied the "going and coming" rule to that portion of the trip in which claimant's injury occurred. We disagree.

As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). Here, however, claimant was not traveling to his workplace in Grants Pass when the accident occurred. Rather, as found by the Referee, claimant's automobile accident occurred while he was traveling on work-related business directly to Salem from Klamath Falls by way of Interstate 5 through Grants Pass. As the court has stated on numerous occasions, "a traveling employee is continuously within the course and scope of employment while away from home, except when engaged in a distinct departure on a personal errand (emphasis supplied)." Proctor v. SAIF, 123 Or App 326 (1993), citing Slaughter v. SAIF, 60 Or App 610 (1982), and Simons v. SWF Plywood Co., 26 Or App 137 (1976). Here, there has been no contention that claimant was on a "personal errand" at the time he was injured. Under the circumstances, we find no basis to analyze any portion of claimant's trip under the "going and coming" rule.

Moreover, the Referee properly analyzed this claim under the factors set forth in Jordan v. Western Electric, 1 Or App 441 (1970). Consequently, we adopt his reasoning and conclusions that claimant has proved that the relationship between the injury and the employment is sufficient that the injury should be compensable.

Claimant is entitled to a reasonable assessed attorney fee for prevailing over SAIF'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 counsel's services on review is $1,200. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 26, 1993, as reconsidered May 26, 1993, is affirmed. For services on review, claimant is awarded an attorney fee of $1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
RICHARD A. PERRY, Claimant
WCB Case No. 92-12470
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Lane, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

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

FINDINGS OF FACT

Claimant worked for the employer as a planer/trim saw operator. His work day began at 6 a.m. with a lunch break from 10-10:30 a.m. and two ten minute breaks at 8 a.m. and 12:00.

On August 18, 1992, at approximately 1:18 p.m., claimant cut off part of his second and third fingers of his right hand while removing a jammed piece of wood from the planer. Claimant received treatment for his injury beginning at 2:05 p.m. At 3:00 p.m., he underwent a blood and urine drug test and tested positive for marijuana.

On September 9, 1992, the employer, pursuant to its drug policy, discharged claimant for failing the drug test. On September 21, 1992, claimant filed a claim with the Bureau of Labor and Industries (BOLI) alleging that he was terminated for making a safety complaint that he had been made to work with an inexperienced employee. BOLI found that the employer had assigned an inexperienced worker to assist claimant. However, BOLI concluded that claimant had been terminated for failing drug testing, and not for making a safety complaint. The employer denied the claim, on October 12, 1992, on the ground that claimant's marijuana use was the major contributing cause of the accident.

Based on the results of the drug tests, Dr. Jacobsen opined that claimant used marijuana sometime between 9 a.m. and the time of claimant's injury. Although Dr. Jacobsen acknowledged that the level of marijuana use could not be equated with the level of impairment, he opined that the acute intoxication effects of marijuana last two to eight hours. The acute effects include, among other things: decreased judgment, impaired concentration, decreased reaction time, impaired motor skill and coordination, increased body sway, and increased impairment where task demands continuous attention and where there are distracting noises. Given the estimated time of marijuana use and the effects of acute intoxication, Dr. Jacobsen opined that claimant was mentally and physically impaired at the time of the accident. He further stated that the type of accident was unlikely given claimant's familiarity with the operation of the machinery and was also indicative of impairment. Based on the above, Dr. Jacobsen concluded that it was more probable than not that claimant's consumption of marijuana was the major contributing cause of the injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's injury could have been caused by claimant being distracted by an inexperienced coworker or that it could have been caused by being impaired due to claimant's use of marijuana. Because there was more than one plausible explanation for the injury, the Referee concluded that the employer had failed to prove, by clear and convincing evidence, that the major contributing cause of the injury was claimant's unlawful consumption of a controlled substance. We disagree.

In Grace L. Walker, 45 Van Natta 1273 (1993), aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994), we held that under ORS 656.005(7)(b)(C) the claimant must first establish a prima facie case of compensability. If so established, then to defeat a finding of compensability, the carrier must carry the burden of proving, by clear and convincing evidence, that the claimant's consumption of alcoholic beverages or the unlawful consumption of any controlled substance was the major contributing cause of the injury. We further stated that the carrier could not meet its burden by merely showing that the claimant consumed alcohol or a controlled substance. Rather, the carrier must clearly and convincingly establish that the claimant was impaired by the alcohol or controlled substance and that such impairment was the major contributing cause of the injury.[1] 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 employer does not contest that the injury occurred in the course and scope of employment and was a material contributing cause of claimant's disability and need for treatment. Therefore, the employer must prove by clear and convincing evidence that claimant's consumption of marijuana was the major contributing cause of the injury. Grace L. Walker, supra.

Claimant testified that he injured his hand while trying to remove a piece of wood from the saw he was operating. While grabbing for the wood, he was looking behind him to make sure an inexperienced coworker, Gilmer Goncora, was out of the way. (Tr. 13-15, 44-46). Claimant testified that Mr. Goncora had been assigned to work as the planer feeder. (Tr. 13). Mr. Goncora did not testify at hearing.

Zane Burke, claimant's supervisor, testified that Mr. Goncora was not assigned to work with claimant nor was he working in claimant's area. Rather, Mr. Goncora was working below the planer area performing clean up duties. (Tr. 61, 63-65, 91-92). Mr. Burke testified that Mr. Goncora was not trained to run the machinery and, therefore, he would not have been assigned to the planer feeder job. (Tr. 62, 65). Mr. Burke testified that from approximately 12:45 p.m., claimant was performing both the sawyer and the planer feeder jobs. (Tr. 66). Claimant had performed both jobs together before. The testimony of Mr. Showerman, sawmill superintendent, supported Mr. Burke's testimony that Mr. Goncora was not assigned to the planer feeder position. (Tr. 105-108).

The Referee relied on BOLI findings and on the employer's failure to call Mr. Goncora as a witness to find that the accident could have been caused by claimant's distraction by an inexperienced coworker. We do not find the BOLI findings determinative on the issue of whether or not Mr. Goncora was assigned to work with claimant. See e.g., Eric S. Gehrs, 45 Van Natta 1727 (1993). The witnesses, upon which the BOLI findings were made, were not subject to cross-examination as were Mr. Burke and Mr. Showerman; nor was the issue of Mr. Goncora's work assignment dispositive to the BOLI ruling. The employer's failure to call Mr. Goncora was also not fatal, given the persuasive testimony from Mr. Burke, as supported by Mr. Showerman, that it was highly unlikely that Mr. Goncora was assigned to work with claimant.

Although the Referee found claimant credible regarding Mr. Goncora's work assignment, the Referee found claimant not credible regarding his marijuana use the day of the accident. Claimant specifically denied using marijuana on that day. The Referee, however, found that the medical evidence directly refuted this testimony. Moreover, claimant's testimony that Mr. Goncora was assigned to work with him was not otherwise corroborated at hearing, but rather was refuted by the testimony of Mr. Burke and Mr. Showerman. Mr. Burke credibly testified that, immediately after the incident, claimant ran over to him and said "I * * * * up. I cut my * * * * fingers off." (Tr. 67). Claimant did not state, at that time, that Mr. Goncora was in his way or that he had been distracted by Mr. Goncora. Claimant's statements to Dr. Scott and to the BOLI investigator blaming the coworker were made after he had been fired for failing a drug test.

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[1] Board Member Gunn would point out that in this case, as in Walker, supra, the only medical evidence of impairment and the amount of contributing factor of that impairment was provided by the employee. Such unrebutted evidence will continue to satisfy the employer's burden as it did in Walker, supra.

As discussed above, the BOLI findings are insufficient to support claimant's position, particularly in light of our finding claimant not credible. Thus, claimant's contention that the injury was caused by being distracted by a coworker is not established on this record. We, therefore, find that claimant's alleged distraction is not a plausible explanation for the accident.

Nevertheless, the question remains whether the employer has met its burden of proving that claimant's consumption of marijuana was the major contributing cause of the accident. Resolution of this issue is a medical question requiring competent medical evidence. Kassahn v. Publishers Paper Company, 76 Or App 105 (1985).

The only medical opinion is from Dr. Jacobsen, an expert in addiction medicine. Dr. Jacobsen testified that acute intoxication effects of marijuana last between two to eight hours and that the associated drug effects persist after intoxication has passed for four to eight hours. (Ex. 13-4; Tr. 129). However, the level of marijuana concentration cannot be equated with the level of impairment. (Tr. 129, 156). The acute effects cause two types of impairment: (1) decreased cognitive judgment and (2) physical impairment. (Ex. 13-4; Tr. 130-132, 180). Dr. Jacobsen explained that the acute effects from marijuana reach a maximum during the two to three hours immediately following its use. (Ex. 13-4). Based upon the results of drug testing, Dr. Jacobsen opined that claimant consumed marijuana on the day of the accident, some time between 9:00 a.m. and the injury at 1:18 p.m. (Ex. 13-3; Tr. 126-127). Dr. Jacobsen, therefore, opined that claimant would have been significantly impaired mentally and physically by marijuana at the time of the accident. He concluded that claimant's consumption of marijuana was the major contributing cause of the injury. (Ex. 13; Tr. 137). Dr. Jacobsen further explained that given claimant's familiarity with the operation of the machinery, this type of accident was unlikely and was indicative of impairment caused by marijuana use. (Ex. 13-5).

We find Dr. Jacobsen's opinion persuasively establishes that claimant's consumption of marijuana, near the time of the accident, caused significant impairment and that impairment was the major contributing cause of claimant's injury. We are, thus, persuaded, by clear and convincing evidence, that the major contributing cause of the accident was claimant's consumption of marijuana. ORS 656.005(7)(b)(C); see Grace L. Walker, 45 Van Natta at 1275. Therefore, the employer has carried its burden of proof that the accident is not compensable.

ORDER

The Referee's order dated April 30, 1993 is reversed in part and affirmed in part. The employer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH E. RICKARD, Claimant
WCB Case No. 91-06676
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

On January 25, 1994, we set aside the insurer's denial of claimant's low back surgery and aggravation claims. Announcing that the parties have resolved their dispute, claimant seeks abatement of our order pending submission of their proposed stipulation.

In light of claimant's unrebutted representation, we withdraw our January 25, 1994 order. On receipt of the parties' proposed agreement, we shall proceed with our review. In the mean time, the parties are requested to keep us fully apprised of any further developments concerning this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD WRIGHT, Claimant
Own Motion No. 93-0757M
OWN MOTION ORDER OF ABATEMENT
Robert J. Guarrasi, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 18, 1994 Own Motion Order in which we declined to reopen his claim for temporary disability compensation because he failed to prove he was in the work force at the time of his July 2, 1993 disability. With his request for reconsideration, claimant submits new information relative to the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA L. YOUNG, Claimant
WCB Case No. 93-01045
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's partial denial of her current back condition. On review, the issue is compensability.

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

The employer is free to partially deny any condition which it reasonably believes could be a claim. Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). However, if the claimant contends that in fact he or she is not making a claim for those conditions, we will set aside the denial as prospective and ineffective for the time being, until such time as claimant actually makes a claim for such conditions. Dorothy Jackson-Duncan, 42 Van Natta (1990); Shannon M. Evans, 42 Van Natta 227 (1990); Alvin H. Despain, 40 Van Natta 1823 (1988).

To the extent that claimant attempted to raise the issue of premature denial at hearing and on review, the attempt is not well taken. (Tr. 2, Claimant's Appellant's Brief, page 11). First, it is not clear that claimant actually raised the issue of premature denial at hearing. Second, she did not seek to have the partial denial set aside for that reason. Third, claimant proceeded to litigate the merits of the denial both at hearing and on review. Proceeding to litigate the merits is a waiver of the procedural defect of a premature denial. See Thomas v. SAIF, 64 Or App 193 (1983); Dorothy Jackson-Duncan, supra.

In any event, we find that claimant made a claim, to which the employer was obligated to respond. A claim is "a written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). The request does not have to take any particular form. A physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition constitutes a claim. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992); William H. Waugh, 45 Van Natta 919 (1993).

Here, both Dr. Gambee, treating physician, and Dr. Kappes, consulting rheumatologist, in reports that discussed claimant's compensable back strain injury, diagnosed an underlying inflammatory spondylitis (ankylosing spondylitis) and recommended anti-inflammatory medication. (Exs. 32-2, 34).

These reports would lead a reasonable employer to conclude that workers' compensation liability was a possibility, thereby obligating the employer to accept or deny the claim. The employer, therefore, properly issued a denial of a condition which it reasonably believed could be a claim. Weyerhaeuser Co. v. Warrilow, supra.

As to the merits of the denial, the employer accepted a thoracic/lumbar strain. (Ex. 16). Claimant was later diagnosed with an underlying condition of ankylosing spondylitis. The parties do not contend and the record does not support a finding that the compensable injury combined with the underlying condition to cause or prolong disability or a need for treatment. Therefore, ORS 656.005(7)(a)(B) does not apply and claimant need not prove that the injury remains the major contributing cause of the disability or need for treatment. Instead, claimant must establish that the injury is a material contributing cause of her disability or need for treatment.

However, claimant fails to meet this burden of proof. We agree with the Referee's reasoning and conclusions regarding the compensability of claimant's current condition.

ORDER

The Referee's order dated June 1, 1993 is affirmed.

In the Matter of the Compensation of
SHERRY V. DROBNEY, Claimant
WCB Case No. 93-00292
ORDER OF ABATEMENT
Francesconi & Busch, Claimant Attorneys
Cummins, et al., Defense Attorneys

Claimant requests reconsideration of our January 26, 1994 order that had reversed a Referee's order affirming a Director's order under ORS 656.327(2) which had found claimant's right leg surgery to be inappropriate. Concluding that the Director's order was not supported by substantial evidence, we set aside the order and found that the self-insured employer was responsible for the surgery. Asserting that she has finally prevailed from a decision denying compensation, claimant seeks a carrier-paid attorney fee award under ORS 656.386(1).

In order to further consider claimant's request, we withdraw our January 26, 1994 order. In addition, we implement the following supplemental briefing schedule. The self-insured employer's supplemental response shall be due 14 days from the date of this order. Claimant's supplemental reply shall be due 14 days from the date of mailing of the employer's response. Thereafter, we shall take this matter under advisement.

In submitting their respective positions, the parties are requested to discuss the effect, if any, the following holdings have on this issue: SAIF v. Allen, 124 Or App 183 (1993); Daniel K. Bevier, 46 Van Natta 215 (1994) (a copy of the Bevier decision is enclosed with counsels' copies of this order); and Sherry A. Young, 45 Van Natta 2331 (1993).

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHELLE CADIGAN, Claimant
WCB Case No. 93-00696
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Podnar's order that affirmed an Order on Reconsideration that awarded her 7 percent (22.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant, age 28, compensably injured her low back. Her job at the time of injury was Department Manager (DOT # 299.137-010). She was released to regular work without restrictions. She was medically stationary on May 13, 1992. The insurer issued a Notice of Closure on August 6, 1992 awarding her no permanent disability. An Order on Reconsideration awarded 7 percent (22.4 degrees) unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Claimant does not dispute the 7 percent rating for impairment. However, she contends that she is entitled to ratings for adaptability, age and education. We disagree.

In response to the Supreme Court's decision in England v. Thunderbird, 315 Or 633 (1993), discussed below, the Director promulgated temporary rules concerning age, education and adaptability. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Under those temporary rules, a worker was entitled to a value for age, education and adaptability, subject to other criteria, where the worker returned to regular work following the compensable injury. See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

The temporary rules set forth in WCD Admin. Order 93-052 applied to all ratings of permanent disability made after June 17, 1993. See Erma J. Jones, 45 Van Natta 2274 (1993). However, those temporary rules expired on December 14, 1993. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056.

The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2).

Claimant became medically stationary on May 13, 1992, and her claim was closed by Notice of Closure on August 6, 1992. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the Notice of Closure. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 6-1992. Thus, the issue is whether claimant is entitled to a value for adaptability under the relevant standards. To fully address this question, it is necessary to review the Supreme Court's decision in England, supra.

In England v. Thunderbird, 112 Or App 324 (1993), the Court of Appeals affirmed our order holding that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a) (providing that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work) were not inconsistent with former ORS 656.214(5) (which provided that "[e]earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job.") However, the Supreme Court reversed the Court of Appeals decision. England v. Thunderbird, 315 Or 633 (1993).

Noting that "earning capacity" under the former statute was an inexact term, the Supreme Court declared that its role was to determine whether the agency "erroneously interpreted a provision of law" (ORS 183.482(8)(a)) and that the ultimate interpretative responsibility rested with the Court in its role as the arbiter of questions of law. See Springfield Education Assn. v. School Dist., 290 Or 217, 234 (1980). Turning to the former statute, the Court determined that the legislature had chosen to list four factors (age, education, impairment and adaptability) which must be "considered" in rating a worker's permanent loss of earning capacity.

Reasoning that post-injury employment may establish earnings but not necessarily establish earning capacity, the Court concluded that the Director's former rules (which gave no value for age, education, and adaptability based on a worker's post-injury earnings) were contrary to the legislative intent.

This case is subject to an amended version of the aforementioned statutes. In 1990, the Legislature amended ORS 656.214(5), which now provides, in relevant part:

> "[T]he criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)." (Emphasis supplied).

The language in former ORS 656.214(5)("[e]earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job."), which had been the basis for the Supreme Court's rejection of the Director's former rules, was deleted from the current version of the statute. In its place is language stating that earning capacity is to be calculated "using the standards specified in ORS 656.726(3)(f)." ORS 656.726(3)(f)(A) provides:

> "The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the injury as modified by the factors of age, education and adaptability to perform a given job." (Emphasis supplied).

ORS 656.726(3)(f)(A) does not contain language such as taking "into consideration" factors of age, education or adaptability, nor does it contain language concerning a worker's ability to obtain and hold gainful employment in the broad field of general occupations. Instead, the Director is authorized to adopt disability standards based on injury-related impairment as modified by the factors of age, education, and adaptability to perform a given job.

Pursuant to ORS 656.726(3)(f), the Director has promulgated "standards" for the evaluation of disabilities. The "standards" applicable to the present case provide that the rating of unscheduled permanent disability "shall be impairment as modified by age, education (including formal education and skills), and adaptability to perform a given job." Former OAR 436-35-270(2). In conjunction with this provision, former OAR 436-35-310(2) provides:

> "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 (residual functional capacity) for regular work or work requiring greater strength than work performed on the date of injury, the value for factor of adaptability is 0."

Inasmuch as the adaptability factor is used as a multiplier and may have a zero value, it is possible that the "modification" in accordance with the enabling statute will be zero. Nonetheless, such a calculation does not lead to a conclusion that the injury-related impairment was not "modified" by the enumerated factors as required by ORS 656.726(3)(f)(A). Rather, the application of that statute and its accompanying rules has resulted in a determination in this case that the impairment value as modified by the factors recited in the statute constitutes claimant's disability award under the standards.

The former OAR provisions considered by the England Court were invalidated because they circumvented a statutory directive requiring that age, education, and adaptability be "considered" in determining loss of earning capacity. The present statute, however, only requires that those elements be used to "modify" impairment. In other words, there is no longer a statutory mandate that those elements be "considered" beyond the extent required by the Director's "standards."

The dissent contends that despite the Legislature's statutory amendments, these changes had no effect on the ultimate question of rating extent of unscheduled permanent disability. We disagree for the following reasons.

In the construction of amendatory acts, it is presumed that material changes in language create material changes in meaning. Fifth Avenue Corp. v. Washington Co., 282 Or 591, 597 (1978) citing 1A Sutherland, Statutory Construction, Sec. 22.30 (1972). Here, the legislature significantly altered ORS 656.214(5). Specifically, phrases identifying earning capacity in terms of the broad field of general occupations and mandating consideration of certain specified factors were eliminated. In their place, earning capacity was designed to be calculated under the Director's disability standards, whose criteria was required to be a claimant's permanent impairment as modified by age, education and adaptability to perform a given job. To construe this change as the dissent argues, would essentially give no meaning to the statutory amendments. We decline to make such an interpretation of the statute.

The dissent also contends that the Director, by assigning an adaptability value of zero, has not used adaptability in calculating a worker's permanent disability and therefore, the worker's permanent impairment has not been "modified," under ORS 656.726(3)(f)(A). However, as noted by the dissent, the definition of "modify" includes "enlarging or reducing." The statute does not eliminate adaptability, it is used as a modifier. It may enlarge or reduce a worker's eventual award of permanent disability under the standards. For example, if a worker's value for age and education is two, but the adaptability value is zero, the worker's award is reduced, or "modified" by non-impairment factors. Similarly, a worker may have an adaptability value of 2, but a zero value for age and education. Since adaptability is use as a multiplier, the worker's award would have again been reduced or "modified" by non-impairment factors.

In addition, the dissent contends that its position is supported by the Director's current "standards" which use the worker's last 5 years of employment as a baseline to determine a worker's adaptability value. While the Director's current "standards" do use a different method to determine adaptability than the "standards" applicable in this case, the issue here is whether former "standards" exceeded the Director's statutory authority granted in ORS 656.726(f)(A). The fact that the Director has subsequently revised the "standards" has little bearing on the issue of the validity of the former "standards."[1]

Finally, although there is little legislative history regarding the deletions made in ORS 656.214(5), it does appear that the amendments were made in order to give the Director the authority to define earning capacity. In this regard, Representative Mannix stated that "earning capacity will be defined and calculated according to specific standards." House Floor Debates on SB 1197, May 7, 1990. In addition, Ross Dwinnell co-chair of the Governor's Worker's Compensation Labor-Management Advisory committee also indicated that the language was deleted so that only the standards specified in ORS 656.726(3)(f) were referenced with regard to the calculation of permanent disability. Tape Recording, Interim Special Committee on Worker's Compensation, May 3, 1990 Tape 1, Side A.

In light of the substantial change in the language of ORS 656.214(5) and the lack of contrary legislative history, we conclude that the "standards" applicable to this case are within the Director's authority pursuant to ORS 656.726.

Here, claimant's at-injury job was as a department manager. She was released to her regular work without restrictions and did in fact return to her regular work. Accordingly, since claimant's adaptability value is zero under the applicable standards, we agree with and adopt the Referee's

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[1] The dissent cites Stone v. Whittier Wood Products, 116 Or App 427 (1992) on recon 124 Or App 117 (1993) for support of their position. The dispute is Stone, however, involved entitlement to temporary partial disability and the interpretation of the phrase "loss of earning power at any kind of work" as it is used in ORS 656.212. In this case, the Board is interpreting the Director's authority under ORS 656.214(5) and 656.726(3)(f)(A) which govern awards of permanent partial disability and concern the calculation of lost earning capacity (impairment as modified by other factors).

conclusion that the Order on Reconsideration correctly evaluated the extent of claimant's unscheduled permanent disability.[2]

ORDER

The Referee's order dated May 11, 1993 is affirmed.

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[2] We note that while the current "standards" (set forth in WCD Admin. Order 93-056) do not apply to this case, the result would likely be the same under that version of the "standards." That is, there is no evidence suggesting that claimant performed any type of work that required a greater physical functional capacity than medium work in the last five years. Since she was subsequently released to medium work, her adaptability value would be zero. See OAR 436-35-280(1)(a). (The dissent refers the reader to fn. 6).

Member Hall and Member Gunn dissenting.

The majority concludes that the Director's standards, which do not allow a value for age, education, and adaptability when a worker has returned to regular work, are within the Director's authority under ORS 656.726. We believe that the Director has exceeded his statutory authority by promulgating rules which circumvent statutory directives and therefore dissent.

At issue here is former OAR 436-35-310(2),[1] which is the Director's attempt to carry out the charge of providing standards for the evaluation of disabilities, specifically, "unscheduled" disabilities involving loss of earning capacity. ORS 656.726(3)(f)(A). In conjunction with this provision, former OAR 436-35-310(2) provides:

> "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 (residual functional capacity) for regular work or work requiring greater strength than work performed on the date of injury, the value for factor of adaptability is 0."

A former version of this (now former) rule, with the same alleged error, and the former enabling statute (ORS 656.214(5)), were the subject of prior litigation in England v. Thunderbird, supra. It is suggested that since the former enabling statute was amended, the subject version of the rule no longer runs afoul of the statute or of the Court's analysis in England. While England may not technically control the present case, the England analysis is more than merely instructive. Given that the two statutes and the two rules are so similar, the England analysis is directly applicable.

Although ORS 656.214(5) has been amended, it remains unchanged in the most significant particulars. The criteria for the rating of unscheduled permanent disability remains the same: ". . . the criteria for rating of [unscheduled] disability shall be the permanent loss of earning capacity due to the compensable injury." ORS 656.214(5). Here is a side-by-side comparison of the pertinent sections of the statute before and after its amendment in 1990:

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[1] It should be noted that the version of OAR 436-35-310(2) at issue in this case has subsequently been replaced by the Director. Former OAR 436-35-310(2) is only applicable to those claims which were closed prior to December 14, 1993. Claims closed on or after that date are subject to a revised version of OAR 436-35-310(2) which is set forth in WCD Admin. Order 93-056.

Former	Current
"(5) In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job. The term "education" shall include a worker's skills, training, and formal education."	"(5) In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)."

The following is a side-by-side comparison of ORS 656.726(3)(f)(A) before and after amendment:

Former	Current
"(f)(A) Provide standards for the evaluation of disabilities. The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. The term "education" shall include the development of an objective standard for evaluating a worker's skills, training and formal education."	"(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards: (A) The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education, and adaptability to perform a given job."

While, as asserted by the majority, material changes in statutory language creates material changes in meaning, we disagree with the majority that the Legislature did in fact significantly alter ORS 656.214(5). After all, contrary to the majority's reading of the statute, the criteria for rating unscheduled permanent disability (loss of earning capacity) remains identical.

Under former ORS 656.214(5), "earning capacity" was an "inexact term," remaining to be spelled out in an agency rule or order. England, supra at 638. Under the present statute, "earning capacity" is still not defined on the face of the statute, though earning capacity is to be "calculated" using "standards specified in ORS 656.726(3)(f)." See ORS 656.214(5). As quoted above, ORS 656.726(3)(f) requires those

calculating standards to evaluate unscheduled disability based upon permanent impairment as modified by the factors of age, education, and adaptability. In that regard, the current version of ORS 656.726(3)(f) also remains identical to its predecessor. Under former ORS 656.214(5), age, education, impairment, and one's "adaptability to perform a given job" were "considerations." Under the present version of ORS 656.214(5), the reader is directed to ORS 656.726(3)(f) where age, education, and one's "adaptability to perform a given job" are still required to be part of the analysis as modifiers of one's physical impairment.

The word "modify" is defined in Black's Law Dictionary as: "to alter; to change in incidental or subordinate features; enlarge, extend; amend; limit, reduce." Such alteration or change may be characterized, in a quantitative sense, as either an increase or decrease. Black's defines "consideration" only in contractual terms, so we turn to Webster's Dictionary for a definition: "continuous and careful thought; something considered as a ground, reason; a taking into account." In its statutory context, modification reflects a stronger mandatory role for the factors of age, education and adaptability than did the former consideration of those factors.

The phrase "ability to obtain and hold gainful employment in the broad field of general occupations," was deleted in the amendment to ORS 656.214(5). The effect of deleting that language was to narrow the scope of analysis from the entire world of work to a more standardized format.[2] The amendment did not, however, eliminate earning capacity or adaptability. The amendment did not reduce unscheduled disabilities to only a physical loss of use (impairment) as is the case for scheduled disabilities. The "calculation" of earning capacity must still take into account one's adaptability. Consequently, if an injured worker's physical impairment permanently reduces that person's ability to perform a given job, which they have previously demonstrated the ability to perform, that worker is entitled to an award reflecting that "modification."

As with the former version addressed in England, the present version of ORS 656.214(5) still reflects the legislature's choice of ". . . permanent loss of earning capacity, rather than the loss of earnings, as the criterion for rating of disability." (England at 639, original emphasis). The legislature's choice of lost earning capacity rather than lost earnings, as the criterion for rating disability, was the cornerstone of the Court's analysis and holding in England.[3] While reference to the "broad field of general occupations" was instructive in defining the breadth of the legislature's former "directive," it was the clear legislative choice between earning capacity and lost earnings which the Court seized upon as the basis for invalidating the predecessor of the rule now at issue. (See England, 315 Or 638-639).

Given the identical criteria for rating disability ("loss of earning capacity due to the compensable injury") in both the former and present version of ORS 656.214(5), we conclude, as did the Court in England, that post-injury employment may establish earnings but it does not necessarily establish earning capacity. Consequently, given the makeup of OAR 436-35-310(2), as invalidated by England, and the same makeup of OAR 436-35-310(2) at issue in the present case, we would hold that the subject version OAR 436-35-310(2) is invalid. We borrow the following summary of analysis from England:

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[2] The legislative history cited by the majority only reflects the goal to standardize the process and to require that awards of permanent disability be based upon the criterion set forth in the Director's "standards." Nevertheless, it is axiomatic that the "standards" adopted by the Director must be statutorily valid.

[3] The court's recent decision in Stone v. Whittier Wood Products, 116 Or App 427 (1992) on recon 124 Or App 117 (1993) is also instructive. In Stone, the court concluded that temporary partial disability must be measured by determining the proportionate loss of "earning power" at any kind of work, rather than the proportionate loss of pre-injury wages. In doing so, the court determined that the Board's application of OAR 436-60-030(2) improperly restricted the claimant's temporary partial disability to the actual wage loss, if any, on returning to work (as opposed to the proportionate loss of earning power at any kind of work).

In reaching its conclusion, the Stone court reasoned that an injured worker's post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. Specifically, the Stone court concluded that the proportionate diminution in "earning power at any kind of work" should be determined by evaluating all of the relevant circumstances that affect the worker's ability to earn wages.

While Stone concerned temporary partial disability it supports the conclusion that "earning capacity" like "earning power" should not be measured in terms of just the worker's at-injury job.

> ""7, 8. Through statutory directive and historical interpretation, a person's post-injury earnings cannot solely determine the person's earning capacity. By statutory directive, age, education, impairment, [and] adaptability to perform a given job, * * * are to be considered in determining earning capacity. Former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a) directed that a person's post-injury employment determined whether the key statutory factors in determining earning capacity were considered. That is contrary to the legislative intent; the interpretation is erroneous." (315 Or at 639).

In conclusion, the challenged regulation improperly confines and limits "earning capacity" in relation to an injured worker's job at injury (i.e., regular work).[4]

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[4] The dissent is further strengthened by examining the Director's most recent version of OAR 436-35-310(2). The current rule does not solely use a worker's at-injury job to determine applicability of age, education, and adaptability standards. Rather, it uses a comparison of a worker's base functional capacity (the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the last 5 years) with the worker's post-injury residual functional capacity. OAR 436-35-310(2) & (4). Thus, the current "standards" recognize that a worker's past work history is a more accurate baseline with which to determine a loss of earning capacity than only using the at-injury job.

February 28, 1994 Cite as 46 Van Natta 313 (1994)

In the Matter of the Compensation of
ROBERT RAPPIN, Claimant
WCB Case No. 92-01691
ORDER ON REVIEW
Richard F. McGinty, P.C., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Garaventa's order that: (1) upheld the insurer's partial denial of his claim for low back conditions; (2) upheld the insurer's partial denial of certain medical bills; and (3) declined to assess a penalty or related attorney fee for the insurer's allegedly unreasonable delay in paying medical bills. Claimant contends that the Referee erred in denying his requests for continuance of the hearing. He requests that his claim be remanded to the Referee for additional evidence taking. On review, the issues are evidence and remand.

We deny the motion to remand and, on the merits, affirm and adopt the Referee's order with the following supplementation.

Prior to hearing, in January 1993, the insurer's counsel offered into evidence, with a copy to claimant's counsel, Dr. Orwick's (claimant's attending physician) written concurrence to a letter drafted by the insurer's counsel. The document was marked as Exhibit 69. Subsequently, the parties arranged for a deposition of Dr. Orwick, scheduled for March 26, 1993. The hearing was convened on March 10, 1993. At that hearing, the insurer's counsel withdrew Exhibit 69 and asserted there would be no further need for a deposition of Dr. Orwick. Claimant's counsel moved for continuance of the hearing: (1) to obtain a report from Dr. Orwick; (2) to depose Dr. Buza, who authored prior medical reports that were admitted into evidence; or (3) based on "surprise." The Referee denied the motions.

On review, claimant requests remand "for completion of the record," explaining that he was surprised by the insurer's withdrawal of Exhibit 69. Claimant also argues that equitable estoppel applies to bar the insurer from opposing his request for a deposition. Claimant's arguments are without merit.

The parties scheduled a deposition of Dr. Orwick in order to allow claimant an opportunity to present final rebuttal evidence in response to Dr. Orwick's opinion in Exhibit 69. However, the insurer's withdrawal of Exhibit 69 extinguished the basis for the deposition, because there was no longer any report for claimant to rebut. Therefore, we do not find that a continuance was necessary for claimant to obtain final rebuttal evidence. See OAR 438-06-091(2).

Further, claimant had ample opportunity to obtain a deposition of Dr. Buza, whose reports were previously disclosed to claimant. Yet, claimant did not avail himself of that opportunity until the date of hearing. Accordingly, we do not find that claimant made a showing of due diligence to justify a continuance. See OAR 438-06-091((3).

We also do not find there were extraordinary circumstances beyond claimant's control to justify a continuance. See OAR 438-06-081, 438-06-091(4). In addition, inasmuch as we do not find that the insurer's counsel made any misrepresentation of material fact or engaged in any "misleading" conduct, the doctrine of equitable estoppel does not apply here. See Swift & McCormick Metal Processors v. Durbin, 117 Or App 605 (1993). Accordingly, we do not find that the Referee abused her discretion in denying claimant's motions. See James D. Brusseau II, 43 Van Natta 541 (1991). Finally, we do not find that this case was "improperly, incompletely or otherwise insufficiently developed or heard" by the Referee so as to justify remand. See ORS 656.295(5).

ORDER

The Referee's order dated June 4, 1993 is affirmed.

February 28, 1994 Cite as 46 Van Natta 314 (1994)

In the Matter of the Compensation of
JUANITA A. RAVENCROFT, Claimant
WCB Case No. 91-09049
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband, Gunn, and Haynes.

The insurer requests review of that portion of Referee Brown's order that granted permanent total disability, whereas an Order on Reconsideration had awarded 46 percent (147.2 degrees) unscheduled permanent disability for a low back injury, 14 percent (21 degrees) scheduled permanent disability for loss of use or function of claimant's left leg and 9 percent (13.50 degrees) scheduled permanent disability for loss of use or function of her right leg.

On review, the issue is permanent total disability and, potentially, extent of permanent partial disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of finding number 9. Claimant was monitoring several elderly ladies at a foster-care facility at the time of hearing, not babysitting.

CONCLUSIONS OF LAW AND OPINION

At the time of her compensable low back injury, claimant was employed as a dishwasher/kitchen aide. After she underwent low back surgery on August 18, 1990, her claim was closed by an August 26, 1991 Determination Order. Claimant was awarded 42 percent unscheduled permanent disability, 14 percent scheduled permanent disability for her left leg and 9 percent scheduled permanent disability for her right leg. By Order on Reconsideration of October 4, 1991, the unscheduled award was increased to 46 percent.

Claimant was 66 years old at the time of claim closure, with a 9th grade education. Claimant was working at the time of hearing at a foster-care facility, supervising three elderly ladies. She worked one day every two weeks for six hours a day and received $5 per hour. The work consisted of monitoring the elderly women while reclining on a couch and also preparing and serving a light lunch.

A physical capacities evaluation conducted at Rogue Valley Medical Center determined that claimant could not maintain sedentary-light employment for an eight hour day, although some inconsistencies and pain behaviors were noted by the evaluators. (Ex. 38). Claimant's attending physician, Dr. Kirkpatrick, recommended that claimant lift no more than 15-20 pounds, but he noted that the physical capacities evaluation was somewhat conservative. (Ex. 40-7, 8).

Claimant testified that she never intended to retire prior to her injury, but that she did not look for work for approximately one year after her surgery. Claimant also testified that her husband underwent heart surgery in February 1992 and back surgery in July or August 1992. She did not seek employment until an unspecified point in 1992 because she felt she needed to care for her husband. Claimant specifically refused vocational assistance in April 1992 because of her husband's medical problems.

The Referee found that claimant was incapable of regularly performing work at a gainful and suitable occupation, regardless of her part-time work. Consequently, the Referee held that claimant was permanently and totally disabled. We agree.

Gainful Occupation

The insurer contends that claimant's part-time employment at the foster-care facility is a "gainful" occupation as defined in Tee v. Albertson's, Inc., 314 Or 633 (1992). In Tee, the Court held that "gainful" in the definition of permanent total disability in ORS 656.206(1)(a) means for "profitable remuneration." The insurer asserts that claimant's part-time employment is "gainful" because she is paid a wage which constitutes "profitable remuneration." The insurer's argument notwithstanding, we do not believe that Tee is controlling in this case.

ORS 656.206(1)(a) provides that a claimant is permanently and totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." In Tee, the claimant was capable of regularly performing work as a telemarketer or hotel/motel inspector and such work was available. The issue was whether the telemarketing and hotel/motel inspector positions for which the claimant was qualified were "gainful" occupations under ORS 656.206(1). Unlike Tee, the question here is whether claimant is employable, i. e., capable of regularly performing work in any suitable occupation in the "normal" labor market. Assuming she is, the issue would then be whether claimant's monitoring activity is "gainful." We find support for our determination in Allethe P. Yngsdahl, 46 Van Natta 111 (1994).

In Yngsdahl, the claimant was performing work as an employee entrance watch guard. This work consisted of the claimant sitting on a stool near the entrance to the employer's store to ensure that only authorized personnel entered the store. The claimant worked 3 hours a day for 4 days a week and was paid $8.40 per hour. The Referee found that such employment was "gainful" under Tee v. Albertson's, supra, and that, therefore, the claimant was not permanently and totally disabled.

We reversed the Referee, holding that, before there is a determination of whether a job the claimant is performing is "gainful," the evidence must establish that the claimant is employable in any suitable occupation in the "normal" labor market. Since the claimant was only employable in a specialized position crafted for her physical limitations, the claimant was not employable in a suitable occupation in the "normal" labor market. Therefore, we found that she was permanently and totally disabled.

In so doing, we distinguished Tee, supra, from Harris v. SAIF, 292 Or 683 (1982). We reasoned that where the issue is whether a claimant is employable, such as in this case, Harris controls. In cases where the issue is whether the occupation that the claimant is deemed capable of performing is gainful, then Tee controls.

In light of Yngsdahl, we turn to Harris v. SAIF, supra, for guidance in determining whether claimant is permanently and totally disabled. In Harris, the claimant was able to earn a considerable amount of money through real estate investments and other activities. The Court stated that the determination of permanent total disability does not turn upon whether a claimant has money-earning capacity, but rather upon whether the claimant is currently employable or able to sell his or her services on a regular basis in a hypothetically normal labor market. Harris, supra, at 695. In Harris, the issue was whether the claimant's permanent total disability award should be reduced. The Court wrote that "the fact that a claimant may have an income, even a substantial one, or that he or she is able to perform a variety of activities does not mean ipso facto that he or she is no longer permanently and totally disabled." Harris, supra, at 695, 696.

There is no indication that the Court in Tee intended to disavow its analysis in Harris. Tee, supra, at 642. We, therefore, do not hesitate in applying Harris to this claim. We now proceed to determine whether claimant is able to sell her services on a regular basis in a hypothetically normal labor market. We agree with the Referee that she cannot.

Claimant's employment activities are de minimus. They merely consist of monitoring several elderly ladies and preparing lunch once or twice a month. There is no vocational evidence that claimant's "job" is available in the normal labor market. Although it is unclear just how claimant obtained her job, there is no indication that anyone else had ever performed it prior to claimant. We note claimant's credible testimony that she must recline at least two times in the morning and two times in the afternoon. (Tr. 16). Dr. Kirkpatrick testified that such actions constituted a reasonable approach to her pain management. (Ex. 40-16). Both claimant's and the insurer's vocational consultant testified that claimant was not competitive in the generally recognized labor market because of her need to recline. (Tr. 44, 46, 94). Given the expert medical and vocational testimony, we conclude that claimant is unable to regularly sell her services in the hypothetically normal labor market.

Willingness to Seek Work

The insurer also contends that claimant has failed to satisfy the "seek-work" requirements of ORS 656.206(3), which provides that claimant must establish that she "is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment." Citing ORS 656.283(7), and Bill Long, 45 Van Natta 200, 201 (1993), it asserts that claimant's disability must be determined at the time of the October 4, 1991 Order on Reconsideration. Because claimant refused to participate in vocational services at least through April 1992, the insurer argues, she has failed to demonstrate the willingness to seek employment required by ORS 656.206(3) and SAIF v. Stephen, 308 Or 41 (1989).

While we agree that claimant's "disability" must be rated as of the date of the Order on Reconsideration, the insurer cites no authority for the proposition that a determination of a claimant's willingness to seek work in the context of permanent total disability is limited to the period before the Order on Reconsideration. We decline the insurer's invitation to so hold in this case, particularly where the determination of permanent total disability must be made based on conditions existing at the time of the hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980); Ronald L. Bartlett, 45 Van Natta 948, 949 (1993). In addition, we can consider evidence on extent of permanent disability that could not have been submitted to the Department on reconsideration. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

In light of this authority, we consider the issue of claimant's motivation with the entire record in mind. Claimant testified that she never intended to retire before her original compensable injury. (Tr. 25). The only reason she declined vocational assistance was because of her husband's medical emergency that necessitated her remaining at home to take care of him. (Tr. 24). Claimant undertook job-seeking efforts as soon as the emergency had passed. (Tr. 24). Under these circumstances, the record as a whole establishes claimant's willingness to work, despite her testimony that she did not seek work until 1992, and, by implication, was not seeking work at the time of the October 4, 1991 Order on Reconsideration. (Tr. 28).

Furthermore, we also find that, but for her compensable injury, claimant is willing to work. See SAIF v. Stephen, supra, at 48. The record documents claimant's reasonable efforts to find employment after her husband sufficiently recovered from his medical problems. (Tr. 24, 25). In fact, claimant sought and was able to engage in wage-earning activities as discussed above. Although we have determined that they do not constitute a "gainful occupation" for the purposes of ORS 656.206(1), they still demonstrate claimant's willingness to seek employment. For these reasons, we reject the insurer's contention that claimant has not satisfied the "seek-work" requirements of ORS 656.206(3).

In addition, we find that claimant's physical incapacity in conjunction with her nonmedical disability made a work search futile. See SAIF v. Scholl, 92 Or App 594 (1988). Mr. Green, the vocational consultant who testified on claimant's behalf, stated that it would be futile for claimant to seek work given her need to periodically recline. (Tr. 46). While Mr. Potocki, the insurer's vocational consultant, did not specifically state that it would be futile for claimant to seek work, he did agree that claimant's need to periodically recline would not lend itself to her maintaining a regular work schedule. (Tr. 94). Since Dr. Kirkpatrick testified that it was reasonable pain management for claimant to recline

throughout the day, we find that the vocational evidence establishes that any work search claimant could have undertaken would have been futile.

Undocumented Worker

Finally, the insurer contends that claimant should be denied permanent total disability benefits because she is not a documented worker. Since this issue was not raised at hearing, we will not consider it for the first time on appeal. Eugenio Gonzalez, 45 Van Natta 921, 922 (1993).

Effective Date

The Referee awarded claimant permanent total disability effective August 26, 1991, the date of the Determination Order. The effective date of an award of permanent total disability is the earliest date that all the elements of permanent total disability are established. Adams v. Edwards Heavy Equipment, Inc, 90 Or App 365, 370 (1983); See Arva Perkins, 42 Van Natta 2384, 2387 (1990) (PTD award is effective as of the date the evidence establishes the disability status). In light of this standard, we modify the effective date of claimant's award. We find that claimant's permanent total disability status was not established until the date of the Order on Reconsideration, October 4, 1991, and accordingly modify the Referee's order to so reflect.

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 $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 3, 1993 is affirmed in part and modified in part. Claimant is awarded permanent total disability benefits effective October 4, 1991. Against this award, the insurer is authorized to offset any permanent partial disability benefits paid to claimant on or after October 4, 1991. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

Board Member Haynes specially concurring.

I agree with the majority that, based on the record as developed in this case, claimant is permanently and totally disabled. I write separately, however, because I wish I could dissent.

The majority's analysis avoids the difficult issue of determining whether claimant's job at the foster-care facility constitutes a "gainful" occupation under Tee v. Albertson's, Inc., supra, by first requiring that claimant be employable in the "normal" labor market. The majority relies on our recent decision in Allethe P. Yngsdahl, 46 Van Natta 111 (1994), as support for its analysis. However, what troubles me about our decision both here and in Yngsdahl is the majority's all too apparent eagerness to consider the claimants' employment as somehow not legitimate. I am also troubled by our reliance on the concept of a "normal" labor market. In this day and age, there is certainly nothing "normal" about the job market.

There is no doubt in my mind that there is a very great need for individuals willing and able to perform duties such as claimant here can perform in adult foster-care facilities. Unfortunately, these aspects of this case were not sufficiently developed. In order to find an individual such as this claimant other than permanently and totally disabled, I must have evidence that the position is both "competitive" and "gainful" in a job market. For that reason, I must, with considerable reluctance, specially concur.

In the Matter of the Compensation of
GLADYS M. THEODORE, Claimant
WCB Case No. 90-20641
ORDER ON REMAND
Patrick Lavis, Claimant Attorney
Meyers & Radler, Defense Attorneys

This matter is on remand from the Court of Appeals. Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993). The court has reversed those portions of our prior order, Gladys M. Theodore, 44 Van Natta 905 (1992), which: (1) determined that the Board did not have jurisdiction to consider whether claimant's disputed medical treatment was palliative or curative; and (2) reversed the Referee's assessment of a penalty and related attorney fees for the employer's denial of the compensability of claimant's medical treatment. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right knee on April 8, 1989. After undergoing an arthroscopy, claimant was declared medically stationary in September 1989. A Determination Order awarded no permanent disability, but claimant ultimately received 5 percent scheduled permanent disability by stipulation.

Claimant did not receive any medical treatment after claim closure until July 1990, when she consulted Dr. Baskin, orthopedist. Claimant was experiencing episodes of leg give-way. Dr. Baskin recommended Cybex testing to evaluate claimant's knee weakness and prescribed physical therapy to strengthen the knee when claimant could not perform the Cybex test. In addition, Dr. Baskin ordered another MRI and discussed the possibility of an additional arthroscopic procedure to alleviate claimant's symptoms.

The employer did not pay any of Dr. Baskin's bills and issued an aggravation denial on October 30, 1990. In addition, the employer contended that claimant's current condition was not related to the original knee injury. At the hearing, the employer withdrew the causal relationship aspect of the denial, but contended that claimant's treatment was palliative and therefore not compensable without the Director's approval. See ORS 656.245(1).

The Referee held that claimant's condition had not worsened since the last arrangement of compensation. Therefore, the Referee upheld the employer's denial of aggravation. Persuaded that the treatments were curative, the Referee further found that the employer's failure to pay for Dr. Baskin's treatment was unreasonable. Thus, the Referee set aside the medical treatment portion of the employer's denial. Finally, the Referee awarded a $1,500 employer-paid attorney fee under ORS 656.386(1), assessed a 25 percent penalty on unpaid medical bills and awarded a "penalty-related" attorney fee of $250.

We affirmed that portion of the Referee's order that upheld the aggravation denial, but vacated that portion of the Referee's order which set aside the employer's denial of medical services. Gladys M. Theodore, supra. We reasoned that the dispute about whether claimant's treatment was palliative or curative was within the jurisdiction of the Director. Finally, given the novelty of the jurisdictional issue, we concluded that the employer's denial of claimant's medical treatment was not unreasonable. Therefore, we reversed the Referee's assessment of a penalty and attorney fee for unreasonable denial.

Citing Meyers v. Darigold, Inc., supra, the court reversed our order. It held that, while the dispute regarding whether claimant's treatment was palliative or curative could fall within the Director's jurisdiction under ORS 656.327, no party sought review by the Director. Under such circumstances, the court concluded that jurisdiction over this issue remained with the Board. Accordingly, the court remanded for reconsideration of the palliative/curative treatment, penalties and attorney fee issues.

As previously noted, the Referee held that Dr. Baskin's treatment was curative rather than palliative. Specifically, the Referee reasoned that Dr. Baskin's treatment was intended to diagnose, treat and cure or alleviate claimant's right knee condition. In other words, the Referee determined that Dr. Baskin was trying to determine what was wrong with claimant and fix it. We agree.

OAR 436-10-005(29) defines palliative care as a "medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to heal or permanently alleviate or eliminate an undesirable medical condition." This rule does not require that all medical services on a closed claim be considered palliative. Frank L. Taylor, 45 Van Natta 2224 (1993). Rather, evaluation of the purpose of the disputed medical services must be made without regard to the legal determination of whether or not the claim qualifies for reopening. Thus, the issue of whether medical services are palliative or curative is determined on a case by case basis. Id.

Although this claim does not qualify for reopening because claimant's compensable condition has not worsened, we, nevertheless, find that the disputed medical services are curative. Like the Referee, we are particularly persuaded by the additional diagnostic procedures that Dr. Baskin recommended, such as the MRI and the Cybex testing. Moreover, Dr. Baskin has also considered an additional arthroscopy.

We are mindful that Dr. Baskin has stated that there is no objective evidence that claimant's condition has worsened. However, the fact that the claim does not qualify for reopening does not preclude a finding that claimant's medical services are curative in nature. Frank L. Taylor, supra.

We are convinced that Dr. Baskin provided medical services designed not just to temporarily moderate the intensity of claimant's symptoms, but rather to heal, permanently alleviate or eliminate an undesired medical condition. Thus, these services do not constitute palliative treatment. See OAR 436-10-005(29). At a minimum, these disputed medical services were designed to diagnose claimant's condition for the purposes of evaluating the appropriate course of action to heal, permanently alleviate, or eliminate claimant's condition. Inasmuch as there is no dispute that the services are related to compensable injury and since the services are not palliative treatment, we affirm the Referee's determination that Dr. Baskin's medical treatment is compensable.

We now consider whether claimant is entitled to a penalty and related attorney fee for the employer's denial of the compensability of claimant's medical treatment. In our original order, we reversed the Referee's award of a 25 percent penalty and a separate assessed attorney fee because we did not find the employer's conduct unreasonable in light of the novelty of the jurisdictional issue. However, in doing so, we did not consider the reasonableness of the employer's denial of the causal relationship between Dr. Baskin's medical treatment and claimant's original injury, an issue which the employer withdrew at the hearing.

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 based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id.

While we still consider the employer's denial based on the palliative/curative care distinction to have been reasonable, we find the employer's causal relationship denial to have been unreasonable. The record does not disclose any basis for issuance of a denial based on lack of causation. There was no suggestion in Dr. Baskin's medical reports that claimant's condition was unrelated to her compensable injury.

Since the denial was unreasonably issued, we award a penalty under ORS 656.262(10), to be shared in equal amounts by claimant and his attorney. The penalty is to be based on all compensation (medical bills) due as of the date of the hearing as a result of this order. We reach such a conclusion because the date of the hearing was when the unreasonable denial of causation was rescinded. See Linda M. Akins, 44 Van Natta 108, 111 (1992).

Claimant is not entitled, however, to a separate assessed fee under ORS 656.382(1)for unreasonable resistance to the payment of compensation. Where, as here, a single unreasonable action is relied upon to support both a penalty and attorney fee, only ORS 656.262(10) applies. Martinez v. Dallas Nursing Home, 114 Or App 453 rev den 315 Or 271 (1992). Consequently, we reverse the Referee's $250 carrier-paid attorney fee award.

Claimant has finally prevailed after remand with respect to the compensability of his denied medical treatment. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Cleo I. Beswick, 43 Van Natta 1314, 1315 (1991). Inasmuch as we have affirmed the Referee's order setting aside the medical services denial and awarding an assessed attorney fee of $1,500, it is unnecessary to address claimant's entitlement to an attorney fee for services at the hearing level. Thus, we proceed to address claimant's entitlement to an attorney fee at the Board and court levels.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at both appellate levels regarding the medical treatment issue is $2,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration of our April 30, 1992 and May 6, 1992 orders, the Referee's order dated February 7, 1991 is affirmed in part and reversed in part. Claimant is awarded a penalty equal to 25 percent of all medical bills due as of the date of the hearing as a result of this order. Claimant's attorney shall receive one-half of that penalty in lieu of an attorney fee. The Referee's $250 attorney fee award is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney shall receive an attorney fee, payable by the employer, of $2,000 for services rendered on review at the Board and court.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERNEST E. BACKER, Claimant
WCB Case No. C3-03258
ORDER DENYING RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Liberty Northwest, Insurance Carrier

Reviewed by Board Member Neidig and Hall.

On December 20, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury. As the disposition complied with statutory requirements and applicable administrative rules, we approved the agreement on January 25, 1994.

On February 17, 1994, we received a motion from the insurer to set aside the CDA because of an intentional misrepresentation of material fact. ORS 656.236(1)(b). We treat the insurer's motion as a request for reconsideration of the CDA.

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, the approved CDA was mailed to the parties on January 25, 1994. Thus, to be timely, any motion for reconsideration must have been filed by February 4, 1994. The insurer's request for reconsideration was filed on February 17, 1994. Consequently, we find that the insurer has failed to file its reconsideration request within 10 days of mailing of our final order. Accordingly, because the reconsideration request was untimely, we have no authority to reconsider the CDA. Therefore, we deny reconsideration. OAR 438-09-035.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH A. HAYES, Claimant
WCB Case No. 92-12909
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Baker's order which: (1) set aside its denial of claimant's claim for vestibular disorder, dizziness and vertigo; and (2) awarded a $6,500 insurer-paid attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

Claimant sustained a compensable thoraco-cervical strain on September 8, 1989, when she slipped and fell. Claimant also struck her head in the compensable accident. The issue at hearing was whether claimant's subsequently diagnosed vestibular disorder and complaints of dizziness and vertigo were materially related to the fall and trauma to the head on September 8, 1989. The Referee held that they were, based on the medical opinions of claimant's treating chiropractor, Dr. Hard, and treating neurologist, Dr. Grimm. The Referee discounted the only contrary opinion, that of the examining neurologist, Dr. Brown, on the grounds that he did not have a complete set of medical records on which to base his opinion.

Since neither party contends, and the record does not establish, that claimant's vestibular disorder is a consequence of her compensable cervical and thoracic injury, claimant need only prove that her vestibular condition is materially related to her compensable accident. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark Weidle, 43 Van Natta 855 (1991). Since this claim involves a complex question of medical causation, expert medical evidence is required for its resolution. See Uris v. Compensation Department, 247 Or 420 (1967).

The Referee discounted the opinion of Dr. Brown, the examining physician, because his conclusion that claimant did not have a vestibular disorder related to her compensable injury was based on an incomplete medical history. We agree.

It is clear from Dr. Brown's August 6,1992 medical report that he lacked chart notes from Dr. Campbell, Dr. Sisco, and, most importantly, Dr. Scopes, claimant's naturopathic physician who documented her complaints for a two-year period after her injury. Moreover, Dr. Brown was under the impression that, with exception of notations in the initial medical reports, claimant's complaints of dizziness did not occur for several years after her original injury. Because of this, Dr. Brown was reluctant to ascribe claimant's vestibular symptoms to her slip and fall.

However, as claimant notes, she reported dizziness to Drs. Scopes and Sisco on January 5, 1990, and March 11, 1991. (Exs. 4A-1, 4A-19). Claimant also reported dizziness to Dr. Campbell on July 17, 1991, July 22, 1991, January 27, 1992 and March 16, 1992. (Ex. 14A, 16-5 16-6). Accordingly, Dr. Brown's opinion was based on inaccurate and incomplete information, thereby entitling it to little weight. Somers v. SAIF, 77 Or App 259 (1986).

In contrast, Dr. Grimm based his opinion that claimant's vestibular disorder, dizziness and vertigo were related to her compensable September 1989 slip and fall accident, in part, on claimant's history of intermittent vertigo since her accident. (Exs. 24, 27-11, 27-13). The insurer's contentions notwithstanding, Dr. Grimm's history is supported by Dr. Campbell's and Dr. Scopes' chart notes, to which Dr. Brown apparently did not have access. Accordingly, we give greater weight to Dr. Grimm's medical opinion. In addition, while she conceded that claimant's disorder was outside her area of expertise, Dr. Hard stated that the presence of a vestibular disorder was consistent with the cervical symptomatology that she treated. (Ex. 26-19).

For the above reasons, we agree with the Referee that the opinions of Drs. Grimm and Hard are the most persuasive. We, therefore, find that claimant has sustained her burden of proving a compensable claim for vestibular disorder, dizziness and vertigo.

Finally, the insurer contends that the Referee's attorney fee award was excessive. We disagree.

After considering all the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's services at hearing regarding the compensability issue is $6,500. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

Claimant is also entitled to an assessed attorney fee for her counsel's efforts on review regarding the compensability issue. ORS 656.382(2). After considering all the factors in the aforementioned rule, we find a reasonable assessed attorney fee for claimant's counsel'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 this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for services on review concerning the Referee's attorney fee award. Dotson v. Bohemia, Inc, 80 Or App 233 (1986).

ORDER

The Referee's order dated July 7, 1993 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

March 1, 1994 Cite as 46 Van Natta 322 (1994)

In the Matter of the Compensation of
KEITH D. MILLER, Claimant
WCB Case No. 89-10246
ORDER ON REMAND
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Miller v. Safeway Stores, Inc., 123 Or App 634 (1993). The court has reversed our prior order, which affirmed and adopted that portion of a Referee's order which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Citing Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant has worked for the employer as a grocery clerk since 1978. This case arises from claimant's December 1988 low back injury claim. Prior to this claim, claimant had suffered several compensable low back injuries, beginning in 1975.

A June 24, 1976 Determination Order closed a 1975 injury claim and awarded 10 percent permanent disability. (Ex. 4). A December 1, 1978 Determination Order closed a 1978 injury claim and awarded temporary disability only. (Ex. 12) On July 30, 1979, claimant settled his appeal of the 1978 Determination Order and received an additional 7 percent permanent disability by stipulation. (Ex. 14). His low back problems did not resolve.

After an April 13, 1983 work injury, claimant underwent surgery for a herniated disc at L5-S1. The 1983 claim was closed by a March 15, 1984 Determination Order which awarded 10 percent permanent disability. On September 26, 1984, claimant settled his appeal of the 1984 Determination order and received an additional 7.5 percent permanent disability by stipulation. (Ex. 38). Thus, claimant's prior awards for his low back total 34.5 percent unscheduled permanent disability.

This claim arises from claimant's compensable December 2, 1988 lifting incident. A May 16, 1989 Determination Order closed the claim and awarded 29 percent unscheduled permanent disability. (Ex. 55). A September 26, 1989 Determination Order affirmed the May 16, 1989 Determination Order. (Ex. 62). Thereafter, the claim was reopened for surgery for a herniated disc at L4-5. This most recent claim was closed pursuant to an April 15, 1991 Notice of Closure, with a medically stationary date of February 28, 1991 and no additional permanent disability award. (Ex. 75).

Claimant requested reconsideration and an August 29, 1991 Order on Reconsideration affirmed the April 15, 1991 Notice of Closure in all respects. (Ex. 77). Claimant requested a hearing, appealing the May 16, 1989 and September 29, 1989 Determination Orders, the April 15, 1991 Notice of Closure, and the August 29, 1991 Order on Reconsideration. The Referee deferred all matters arising from the May 16, 1989 and September 29, 1989 Determination Orders. The hearing proceeded concerning the Notice of Closure and reconsideration order.

CONCLUSIONS OF LAW AND OPINION

Claimant appeals the August 29, 1991 Order on Reconsideration, which affirmed the April 15, 1991 Notice of Closure which declined to award additional permanent disability for claimant's low back condition beyond the 29 percent granted by the May 16, 1989 Determination Order.

Claimant requested reconsideration of the April 1991 Notice of Closure, objecting to the impairment findings used to close the claim. The Order on Reconsideration, which issued on August 29, 1991 without prior appointment of a medical arbiter, affirmed the Notice of Closure in all respects. Claimant requested a hearing.

The parties agreed to submit the matter to the Referee on the record. All the exhibits offered were admitted, including the "post-reconsideration" November 15, 1991 medical arbiter's report. The Referee found the Order on Reconsideration invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order and dismissed claimant's request for hearing regarding that order. Claimant requested Board review.

In our prior order, we affirmed the Referee's order. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992). Claimant appealed.

The court has reversed our order, citing Pacheco-Gonzalez v. SAIF, supra. In Pacheco-Gonzalez, noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. Pacheco-Gonzalez, supra.

In this case, relying on the reasoning expressed in Pacheco-Gonzalez, the court has similarly remanded for reconsideration. Accordingly, we proceed with our reconsideration.

As we have stated, the parties agreed to submit the matter to the Referee on the record and all the exhibits offered were admitted, including the "post-reconsideration" November 15, 1991 medical arbiter's report. We requested and received supplemental briefing on the extent of disability issue. Under these circumstances, we consider the record to be sufficiently developed to conduct our review concerning the extent of claimant's permanent disability.

Claimant became medically stationary after July 1, 1990, and he made a request for reconsideration pursuant to ORS 656.268. Therefore, in rating his permanent disability, we apply the disability rating standards in effect on the date of the April 15, 1991 Notice of Closure. OAR 438-10-010, 436-35-003(2). Thus, the applicable "standards" are provided in WCD Admin. Order 2-1991.

The parties agree that claimant's low back range of motion is properly valued at 14 percent. However, they disagree regarding the valuation of claimant's 1989 low back surgery. Claimant argues entitlement to a 9 percent rating for the 1989 surgery at L4-5 "with documented spinal stenosis." (Brief p. 1). We disagree with claimant's assertion.

Although claimant does have documented spinal stenosis, the 1983 and 1989 surgeries were for herniated discs. (See Exs. 19-7, 19-11, 24). Because the 1989 surgery (for a herniated disc at L4-5) was the second surgical procedure resulting from a second intervertebral disc lesion (the first being the 1983 surgery for a herniated disc at L5-S1), the 1989 surgery is rated under former OAR 436-35-350(2)(a). (WCD Admin. Order 2-1991). Thus, claimant is entitled to a value of 1 percent as a "General Spinal Finding" for the second surgical procedure involving an additional disc treated within the low back area. See former OAR 436-35-350(2)(a).

Claimant's range of motion value (14) is combined with his "General Spinal Finding" (1) for a total impairment value of 15.

The parties agree that claimant's age and education total is 4.

Claimant's regular work as a grocery clerk had a strength requirement in the "light" range (DOT 290.477-018). (See Exs. 35, 44, 59-1, 78-2). Although Dr. Golden stated that claimant was released to his regular work after several months of light duty following the 1989 surgery, there is no indication that the restriction against repetitive back motion was ever removed. (See Exs. 74, 78-2). Therefore, we find that claimant did not return to his regular work activities.

Claimant argues that his adaptability factor is 4, because he was bagging groceries ("medium" range, see DOT 920.687-014) when injured in 1988, but now is released to work as a cashier-checker only ("light/sedentary" range, see DOT 211.462-014), with limitations. We disagree.

As previously noted, claimant was a grocery clerk (or cashier-checker) before and after his injury. Although his regular work as a clerk involved some bagging of groceries, we are not persuaded that claimant was primarily a "Bagger" when he was injured. (See Exs. 35, 44, 59-1, 78-2; compare DOT 211.462-014 & 920.687-014).[1] Accordingly, because claimant's job at injury had "light" strength requirements and he was released to that job, with restrictions, after the injury, claimant's adaptability factor is 2. See former OAR 436-35-310(1) and (3).

Assembling the factors, we multiply the age and education factors total (4) and the adaptability value (2) for a product of 8. That product is then added to the impairment value of 15 for a total of 23 percent. See OAR 436-35-280.

The employer argues we must consider claimant's prior disability awards for his low back in evaluating his current claim. See ORS 656.214; former OAR 436-35-007(3). Specifically, the employer contends that claimant is not entitled to permanent disability compensation for his low back in addition to the 34.5 percent which he received prior to the 1988 claim. We agree.

A worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question (the 1988 injury), but which had already been produced by an earlier accident and compensated by a prior award. See Mary A. Vogelaar, 42 Van Natta 2846 (1990). Accordingly, having determined claimant's current extent of disability (23 percent), we next consider whether claimant was previously compensated for this loss of earning capacity (by his prior 34.5 percent award).

Claimant has returned to his regular job for the employer as a grocery clerk (a job which he has performed for over fifteen years). His treating physician released him to perform his regular work with a 25-pound lifting limit and restrictions against repetitive back motions. We acknowledge claimant's work limitations. However, notwithstanding these limitations, in light of the prior 34.5 percent unscheduled permanent disability award, we are not persuaded that the 1988 injury has resulted in additional loss of earning capacity beyond that for which claimant was previously compensated.

Accordingly, on reconsideration, we reverse the Referee's order dated July 10, 1992. Claimant's hearing request is reinstated. The August 29, 1991 Order on Reconsideration, which affirmed the April 15, 1991 Notice of Closure (that declined to award additional permanent disability) is affirmed.

IT IS SO ORDERED.

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[1] Even if claimant's regular job was "Bagger" (medium strength) and his adaptability factor is 4 (because he returned to light work with restrictions), that would not change the result in this case. In other words, claimant's permanent disability under the standards, using an adaptability factor of 4, would be 31 percent. In light of claimant's 34.5 percent unscheduled permanent disability award, we would continue to conclude that claimant has not suffered a loss of earning capacity beyond that for which he was previously compensated.

In the Matter of the Compensation of
JAMES F. SHISSLER, Claimant
WCB Case No. 91-08517
ORDER ON REMAND
Ernest Jenks, Claimant Attorney
Charles Lundeen, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Jones v. Shissler, 124 Or App 205 (1993). The court has reversed our prior order, James F. Shissler, 44 Van Natta 1639 (1992), which vacated for lack of jurisdiction a Referee's order that: (1) set aside the insurer's "de facto" denial of claimant's medical services claim for separate living quarters; (2) awarded claimant's counsel an assessed fee of $2,000 for prevailing against the denial; (3) awarded claimant's counsel an assessed fee of $500 pursuant to ORS 656.382(1) for the unreasonableness of the insurer's denial; and (4) assessed a penalty of 25 percent of the amounts made due by the Referee's order, to be shared equally by claimant and his attorney in lieu of an attorney fee award. Citing Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction.

The first sentence in the paragraph under "Ultimate Findings of Fact" should read: Claimant's present condition includes the diagnosis of "major mental illness." (Emphasis added).

CONCLUSIONS OF LAW AND OPINION

In 1985, claimant sustained a severe compensable open head injury and brain laceration that left him permanently and totally disabled. In July 1987, claimant's treating psychiatrist, Dr. Berger, recommended that claimant move to separate living quarters as part of his ongoing psychiatric care related to his head injury. (Ex. 29). In June 1988 and January 1991, Dr. Berger requested that the insurer provide such living quarters for claimant to stabilize claimant's condition and to minimize his need for hospitalization and agency intervention. (Exs. 34, 60A). The insurer did not respond to these requests.

Thereafter, claimant requested Director review of the insurer's "de facto" denial of claimant's request for separate living quarters. (Ex. 61). Declining to address this "compensability" question, the Director advised claimant to request a hearing before the Board's Hearing Division. (Ex. 62).

Claimant requested a hearing regarding the insurer's "de facto" denial of his claim for separate living quarters. The Referee concluded that, in this case, separate living quarters constituted a compensable medical service, because they would be in lieu of the expensive and frequent hospitalization that would be required if claimant did not have a separate living space.

On review, we vacated the Referee's order, concluding that, under ORS 656.327(1), jurisdiction over disputes regarding the necessity or reasonableness of current or proposed medical services lies exclusively with the Director, whereas disputes regarding the cause for the need for medical services remain with the Board and its Hearing Division. James F. Shissler, supra. The issue in controversy was whether the provision of separate living quarters fell within the phrase "other related services" in ORS 656.245(1)(c). Because the insurer had not contested the causal relationship of the requested medical services to claimant's compensable injury, we concluded that the Director, and not the Board or the Referee, had jurisdiction to adjudicate the matter. Id.

The Court of Appeals disagreed with us, citing Jefferson v. Sam's Cafe, supra. In that case, the court held that, because the Director review process mandated by ORS 656.327 does not apply to requests for future medical treatment, the Board and the Hearings Division have jurisdiction to resolve disputes concerning proposed medical treatment. In light of the court's mandate, we now proceed to address the merits of the controversy.

MEDICAL SERVICES

The Referee set aside the insurer's denial of claimant's medical services claim for separate living quarters. The insurer argues that separate living quarters do not constitute a compensable medical service within the definition of ORS 645.245(1)(c). We disagree.

A carrier must provide medical services for conditions resulting from any compensable injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1)(a). ORS 656.245(1)(c) provides that, in this context, "[c]ompensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative devices." (Emphasis added).

The medical services contemplated by ORS 656.245(1) have been construed to include the removal of architectural barriers in a claimant's home, see Stoddard v. Credit Thrift Corporation, 103 Or App 283 (1990), on remand Frank L. Stoddard, 43 Van Natta 4 (1991), as well as home heath care services. E.g., Robert P. Holloway, Sr., 45 Van Natta 2036 (1993), on recon 46 Van Natta 117 (1994). In Holloway, we held that the claimant's request for home-based assistance with personal hygiene, housekeeping, nursing care and transportation to medical appointments constituted "other related services" under ORS 656.245(1)(c). In doing so, we noted that "[t]he services requested by [the] claimant's attending physician and surgeon were expressly intended to assist [the] claimant in his recovery from surgery." Id. at 2038. For the reasons set forth below, we conclude that claimant's request for separate living quarters is likewise a compensable medical service within the meaning of ORS 656.245(1)(c).

After claimant sustained his compensable head injury in 1985, Dr. Berger diagnosed Organic Personality Disorder. According to Dr. Berger, claimant's disorder has, among other things, resulted in a behavior dysinhibition that has manifested itself in frequent outbursts of anger and physical violence. (See Exs. 29, 34, 44, 58, 60A). Dr. Berger found that claimant's condition was particularly acute while he resided with his wife and their three sons; during those times, claimant frequently became intensely angry and physically abusive, and had suicidal and homicidal ideations. (Ex. 58).

In an effort to resolve this volatile situation, Dr. Berger prescribed the removal of claimant from the family home to a nearby apartment. (Exs. 34, 60A). One of the purposes of this "prescription" was to minimize claimant's need for further hospitalization and agency intervention. (Ex. 34). There is no contrary medical opinion.

On its face, ORS 656.245(1)(c)'s definition of "medical services" includes the gamut of inpatient health care services. What claimant is seeking is merely a "home-based" version of the same environment he would encounter in an inpatient psychiatric facility; that is, a quiet, relatively stress-free environment in which to carry out his activities of daily living. In light of Dr. Berger's uncontroverted opinion that separate living quarters would minimize claimant's need for hospitalization and agency intervention, we conclude that claimant's request for separate living quarters is a compensable medical service within the meaning of ORS 656.245(1)(c).

This case is analogous to the architectural barrier and home health care cases, in that, in all three situations, the claimant sought to receive services that traditionally would have been provided in an inpatient setting. See Stoddard v. Credit Thrift Corporation, supra; Frank L. Stoddard, supra; Robert P. Holloway, supra. The only distinction is that, in the architectural barrier and home health care cases, the claimants had sustained physical injuries, whereas here, claimant has sustained a physical injury for which he requires psychiatric care. We find no reasoned basis for construing ORS 656.245(1)(c) to exclude the provision of home-based psychiatric assistance.

The insurer argues that, because separate living quarters are not of the same type of services specifically enumerated in ORS 656.245(1)(c), the rule of statutory construction, ejusdem generis, leads to the conclusion that the legislature did not intend "medical services" to include separate living quarters. We disagree.

ORS 656.245(1)(c) does not contain an exhaustive list of approved medical services. Because the enumerated services are prefaced with the words "shall include" (emphasis added), we are persuaded that compensable medical services are not limited to the specific examples contained in the statute. In light of the statute's non-exclusive language, and the axiom that workers' compensation laws are to be liberally construed to provide coverage for injured workers, e.g., Holden v. Willamette Industries, 28 Or App 613 (1977), we believe that, under the facts of this case, separate living quarters fall within the scope of medical services contemplated by ORS 656.245(1)(c). We find as further support for this

conclusion the unrebutted opinion of claimant's attending psychiatrist, who explained that the apartment "prescription" was designed to minimize claimant's need for further hospitalization, a service that clearly would constitute a compensable medical service.

Finally, the insurer argues that, under Stritt v. SAIF, 37 Or App 893 (1978), claimant's request for separate living quarters must be denied. We disagree. In Stritt, the court held that former ORS 656.245(1)'s (ORS 656.245(1)(c)'s precursor) definition of medical services did not include moving expenses for someone who was leaving an area to live elsewhere permanently, even though the move was occasioned by a compensable injury. We find Stritt distinguishable from this case for one simple reason: Here, claimant seeks a home-based alternative to one of the services that is specifically enumerated in ORS 656.245(1)(c), viz., hospitalization. In contrast, in Stritt, the service that the claimant sought -- moving expenses -- was neither one of the enumberated services nor its alternative. Accordingly, we reject the insurer's reliance on that case.[1]

ATTORNEY FEES AND PENALTIES

The Referee awarded both an assessed attorney fee of $500 for the insurer's unreasonable "de facto" denial of claimant's medical services claim pursuant to ORS 656.382(1), and, pursuant to ORS 656.262(10), a penalty of 25 percent of the amounts made due by the Referee's order, to be shared equally by claimant and his attorney in lieu of an attorney fee award. A referee may not assess a penalty under ORS 656.262(10) and assess a penalty-related attorney fee under ORS 656.382(1) for the same unreasonable conduct. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Accordingly, we reverse the Referee's $500 attorney fee award.

In a case in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals, or Board in respect to any claim or award for compensation, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). Claimant has finally prevailed on his medical services claim. Therefore, he is entitled to a reasonable attorney fee for services before the Referee, the Board and the Court of Appeals.

Inasmuch as we have affirmed the Referee's conclusion that claimant's request for separate living quarters was a compensable medical service, we adopt and affirm the Referee's award of an assessed fee of $2,000 to claimant's counsel for prevailing against the insurer's "de facto" denial. We now proceed to address the amount of attorney fees claimant should be awarded for services at the appellate levels.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the appellate levels concerning the medical services issue is $3,000, 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 appellate briefs), the complexity of the issue, and the value of the interest involved.

Accordingly, the Referee's order dated December 5, 1991 is affirmed in part and reversed in part. The Referee's $500 attorney fee under ORS 656.382(1) is reversed. The remainder of the Referee's order is affirmed. For services before the Board and the Court of Appeals, claimant's counsel is awarded $3,000, to be paid by the insurer.

IT IS SO ORDERED.

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[1] The insurer also refers us to Lorenzen v. SAIF, 79 Or App 751 (1979), rev den 301 Or 667 (1986), where the court held that child care services were not "other related services" within the meaning of ORS 656.245. Like Stritt, Lorenzen is distinguishable from this case, because child care is neither enumerated in ORS 656.245(1)(c), nor is it an alternative for any of the services that are enumerated in that statute.

In the Matter of the Compensation of
ROBERT E. VANWORMER, Claimant
WCB Case No. 92-02900
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Hall.

Claimant, pro se, requests review of those portions of Referee Michael V. Johnson's order that: (1) upheld the self-insured employer's denial of claimant's claim for a neck and head injury; and (2) found that claimant was not entitled to interim compensation. On review, the issues are compensability and interim compensation. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Referee specifically found claimant not credible based upon his demeanor as well as inconsistencies in the record. The Board ordinarily defers to demeanor-based credibility findings. See Bush v. SAIF, 68 Or App 230 (1984). Although we defer to the Referee's demeanor based credibility finding here, it does not necessarily follow that claimant did not prove his claim. See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991). In order to establish compensability of his claim, claimant must prove that an injury arising out of and in the course of employment was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

There is no dispute that claimant struck his head on a 2x4 brace on November 29, 1991. This event was witnessed by a co-worker. (Tr. 140-141). The medical evidence supports claimant's assertions that he was injured at work. Drs. Rich and Coletti initially examined claimant for the employer in February 1992. At that time, they felt that claimant embellished or exaggerated his symptoms. Nonetheless, they concluded that claimant had suffered some strain to his cervical spine as a result of striking his head on a 2x4 at work on November 29, 1991. Dr. Coletti re-examined claimant on July 10, 1992. Dr. Coletti noted that claimant's cervical range of motion had improved substantially since claimant's last examination. Dr. Coletti felt that claimant's examination was straightforward and he believed that claimant's cervical sprain was medically stationary. (Ex. 27). Dr. MacRitchie and Dr. Schachner also diagnosed claimant's condition as a cervical strain. (Exs. 22; 23; 24; 25). Dr. MacRitchie indicated that the cervical strain had improved.

Based solely on the medical record, we conclude that claimant has established that the November 29, 1991 work injury was a material contributing cause of his cervical strain which has since resolved. In reaching this decision, we note that there is no evidence that claimant's cervical strain occurred off-work. We emphasize that we are only finding a cervical strain compensable. In light of the Referee's finding that claimant is not credible, we conclude that claimant has not established that he suffered any injury other than a cervical strain and a contusion. There is no medical evidence which substantiates claimant's contention that he injured his teeth in the incident.

Interim Compensation

Regardless of whether his claim is compensable, claimant seeks interim compensation beginning January 6, 1992, the date he filled out an 801 form concerning the November 29, 1991 incident. "Interim Compensation" is temporary disability compensation paid between the employer's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n.1 (1984). A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. See ORS 656.262(4)(a); Stone v. SAIF, 57 Or App 808, 812 (1982).

Here, the employer did not receive notification that claimant was off work, ostensibly for reasons related to the injury, until Dr. Dietel's chart notes to that effect were received on January 27, 1992. The employer denied the claim two days later. Under these circumstances, there was no duty to pay interim compensation.

Claimant was represented by counsel at hearing and 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 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 the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 29, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the self-insured employer's denial of claimant's claim for a cervical condition is reversed. The employer's denial is set aside and the claim remanded to the employer for processing according to law. For services at hearing, claimant's attorney is awarded $3,000 payable by the self-insured employer. The remainder of the Referee's order is affirmed.

March 3, 1994 Cite as 46 Van Natta 329 (1994)

In the Matter of the Compensation of
RONALD L. BARTLETT, Claimant
WCB Case Nos. 92-11909 & 92-07871
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Neal's order which declined to award an attorney fee pursuant to ORS 656.386(1) for claimant's attorney's services in obtaining a pre-hearing rescission of the compensability portion of Mid-Century Insurance Company's (Mid-Century) "compensability/responsibility" denial. Mid-Century cross-requests review of those portions of the order that: (1) set aside its disclaimer of responsibility for claimant's occupational disease claim for hearing loss and tinnitus conditions; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) disclaimer of responsibility for the same conditions. On review, the issues are responsibility and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that Liberty established that Mid-Century is responsible for claimant's hearing loss and tinnitus conditions, because claimant's exposure with Liberty's insured did not contribute to the conditions. In reaching this conclusion, the Referee relied on the opinion of Dr. Epley, otologist. We disagree.

The parties do not dispute the Referee's finding that responsibility is initially assigned with Liberty, as the last insurer on the risk during the last potentially causal work exposure. We agree and adopt the Referee's reasoning in this regard, through the first full sentence on page 3.

The issue is whether responsibility shifts to Mid-Century, the prior insurer.

In order to shift responsibility to Mid-Century, Liberty must establish that the prior work conditions were the sole cause or that it was impossible for work conditions during the last employment to have caused claimant's disease. See FMC Corporation v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

The medical evidence concerning causation is provided by Michael Fairchild, audiologist, and Dr. Epley, otologist. Mr. Fairchild and Dr. Epley initially stated that they could not say how much claimant's exposure with Mid-Century's insured actually contributed to claimant's condition, because no audiograms were performed during that time. (Exs. 22, 27). Thereafter, having reviewed information about claimant's work conditions after 1986, Dr. Epley opined that claimant's earlier employment under Mid-Century's coverage, was the "major cause" of the hearing loss. (Ex. 36). Based on his understanding that claimant "spent his time doing paperwork in the office" during Liberty's coverage, Dr. Epley concluded that there was "no evidence that [work conditions during Liberty's coverage] would have contributed" to the condition. (Id).

However, considering claimant's testimony regarding his work conditions over the years, we are not persuaded that Dr. Epley's changed opinion is based on an accurate history. Specifically, we find that claimant was still exposed to noise capable of causing hearing problems during his later employment under Liberty's coverage. Under these circumstances, Dr. Epley's opinion claimant's exposure with Liberty's insured was noncontributory is unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Finally, we note that Dr. Epley later conceded that it was "possible" that claimant's exposure during Liberty's coverage did contribute to claimant's hearing loss. (Ex. 37-16).

On this evidence, we cannot say that conditions during Mid-Century's coverage were the sole cause of claimant's hearing loss and tinnitus conditions or that it was impossible for conditions during Liberty's coverage to cause the conditions. Consequently, Liberty remains responsible.

Attorney fees

The Referee declined to award an attorney fee pursuant to ORS 656.386(1) for claimant's attorney's services in obtaining pre-hearing rescission of the compensability portion of Mid-Century's denial.

Since the Referee's order, we have held that claimant's counsel is entitled to a carrier-paid attorney fee under ORS 656.386(1) when a carrier rescinded the compensability portion of its denial prior to a hearing regarding responsibility for the claim. Penny L. Hamrick, 46 Van Natta 14 (1994); see Dale A. Karstetter, 46 Van Natta 147 (1994).

Here, because Mid-Century's compensability denial put claimant's compensation at risk and claimant's counsel was instrumental in obtaining rescission of that denial without a hearing, claimant is entitled to an attorney fee under ORS 656.386(1). Penny L. Hamrick, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $500 is a reasonable assessed attorney fee for claimant's counsel's pre-hearing services concerning the rescission of the compensability portion of Mid-Century's denial. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Finally, because claimant's attorney filed no brief on Board review, no additional attorney fee is awardable. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated April 20, 1993, as reconsidered May 6, 1993, is reversed. Mid-Century Insurance Company's responsibility disclaimer is reinstated and upheld. Liberty Northwest Insurance Corporation's disclaimer is set aside and the claim is remanded to it for processing according to law. For pre-hearing services concerning the compensability portion of Mid-Century's denial, claimant's counsel is awarded a $500 attorney fee, payable by Mid-Century.

In the Matter of the Compensation of
STEVEN E. BRADLEY, Claimant
WCB Case Nos. 92-07698, 92-07599,92-04964, 92-05726, 92-05484, 92-14655, 92-08221 & 92-05483
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Stoel, et al., Defense Attorneys
Beers, Zimmerman, et al., Defense Attorneys
Gary T. Wallmark (Saif), Defense Attorney
Rowell & Wickersham, Attorneys
Meyers & Radler, Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (on behalf of C.C. Meisel Company) requests review of Referee Herman's order that: (1) set aside its denial of claimant's occupational disease claim for his bilateral hearing loss condition; (2) upheld the SAIF Corporation's denial (on behalf of Rowell & Wickersham Contractors) of claimant's claim for the same condition; (3) upheld SAIF's denial (on behalf of C.C. Meisel) of claimant's claim for the same condition; (4) upheld The Fire & Casualty Insurance Company of Connecticut's denial (on behalf of C.C. Meisel, dba/By-Town Pipe) of claimant's claim for the same condition; and (5) upheld the self-insured employer's (C.C. Meisel/Maryland Casualty) denial of claimant's claim for the same condition. In his brief, claimant contends that the Referee's attorney fee award of $3,000 should be increased. On review, the issues are compensability and attorney fees.

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

On review, Liberty contends that claimant's bilateral hearing loss condition is not compensable because claimant's treating doctor, Dr. Pfendler, testified that claimant did not have measurable hearing loss as defined under the "standards." However, we addressed a similar argument in James F. Plummer, 45 Van Natta 1477 (1993). In Plummer, we concluded that the critical determination concerning compensability of an occupational disease claim remains whether the claimant has proven that his work activities were the major contributing cause of his bilateral hearing loss condition. Accordingly, we are not persuaded by Liberty's argument that such a factor precludes claimant from establishing compensability.

Furthermore, after reviewing the testimony of Dr. Pfendler and the rest of medical and lay evidence, we agree with the Referee's conclusion that claimant has established compensability. Dr. Pfendler was aware of claimant's prior hearing loss condition, his off work activity and his exposure to noise at work. Under the circumstances, we find Dr. Pfendler's opinion persuasive and we conclude that claimant has proven that work exposure was the major contributing cause of his worsened hearing loss condition.

Finally, after considering all the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's services at hearing is $3,000. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

Because compensability was at issue at hearing and on review, claimant is entitled to an assessed attorney fee for services on review, to be paid by Liberty. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $800 is a reasonable assessed attorney 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 respondent's brief), the complexity of the issue and the value of the interest involved. We further note that claimant's counsel is not entitled to a fee for services on review devoted to the attorney fee issue.

ORDER

The Referee's order dated June 18, 1993 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 92-06386
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The self-insured employer requested reconsideration of our November 16, 1993 Order on Review. The employer objected to that portion of our order that concluded that it had previously accepted claimant's preexisting degenerative lumbar condition when it accepted her injury claim pursuant to the 801 injury claim form. Specifically, the employer contended that claimant had not raised a "back-up" denial theory of compensability at hearing.

On December 15, 1993, we abated our November 16, 1993 Order on Review to further consider the employer's request and provide claimant an opportunity to respond to the employer's motion. Having received claimant's response, we proceed with our reconsideration.

We briefly summarize the procedural history of the case. On April 25, 1989, claimant filed an 801 form, indicating that she had been experiencing low back and abdominal pain since October 11, 1988 as a result of wearing a gunbelt. On May 25, 1989, the employer accepted claimant's condition as a disabling injury by checking the appropriate boxes on the 801 form. On April 17, 1992 (almost three years later), the employer issued a denial of claimant's degenerative lumbar spine condition as "preexisting and not relat[ed] to your [October 11, 1988] injury." Claimant requested a hearing regarding the employer's denial.

Reasoning that claimant's work activities were the major contributing cause of a worsening of her underlying degenerative lumbar condition, the Referee set aside the employer's denial of that condition. The Referee further awarded claimant an insurer-paid attorney fee. The employer requested Board review of the Referee's order. In our prior decision, we affirmed the Referee's ultimate conclusion, but found instead that the employer's denial constituted an improper "back-up" denial under ORS 656.262(6). See Susie A. Fimbres, 44 Van Natta 1730, 1732 (1992), rev'd on other grounds, Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993).

Thereafter, the employer requested reconsideration of our decision. The employer asserts that claimant did not contend at hearing that it had accepted her preexisting lumbar degenerative disc disease. Therefore, it argues, the Board erred in deciding the case on an alternate theory of compensability. In response to our abatement order, claimant concedes that she did not raise a "back-up" theory of compensability at hearing. Nevertheless, contending that the record is fully developed to properly address this theory, claimant argues that the employer was not prejudiced by the Board considering a "back-up" denial theory. Therefore, claimant asserts, "fundamental fairness" and "substantial justice" require the Board to exercise its discretion and consider alternate legal theories that are based on evidence in the record.

Generally, we do not consider for the first time on review a theory that was not raised at hearing. See Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993) (Board declined to consider a carrier's challenge to a compensability claim based on insufficiency of medical evidence when the carrier had only contested the claim on "not arising out of employment" grounds at the hearing); Karen K. Malsom, 42 Van Natta 503 (1990) (Board declined to consider a carrier's challenge to an aggravation claim based on no worsening when the carrier had only contested the claim on causation grounds at the hearing).

Here, in her pre-hearing specification of issues, as well as at hearing, claimant identified the issue as, inter alia, the employer's "current condition" denial. In recorded closing arguments, claimant acknowledged that the employer's denial was not an attempt to limit or modify its "801 acceptance." Later, she reiterated that there had been "no attempt by the employer to back up and deny [the accepted condition]." (Tr # 2, pg. 61)

In light of claimant's representations at hearing, we conclude that the Board erred in its original order on review by raising the "back-up" denial theory of compensability on its own motion and for the first time in this case. Accordingly, we grant the employer's motion for reconsideration, and replace our prior order with the following order.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the third sentence in Fact number 10.

CONCLUSIONS OF LAW AND OPINION

Compensability

The employer's denial of claimant's degenerative lumbar spine condition as preexisting and not related to her injury was a "resultant" condition denial. See ORS 656.005(7)(a)(B) (if a compensable injury combines with a preexisting condition, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability of need for treatment). Notwithstanding this theory, the parties litigated the claim based on claimant's contention that her preexisting degenerative condition worsened as the result of wearing a gunbelt at work; i.e., an occupational disease theory. Moreover, the Referee analyzed the claim as an occupational disease claim under ORS 656.802(2). Whether the claim is analyzed as an occupational disease claim or as a "resultant" condition claim, the standard of proof is major contributing cause. Consistent with the parties' arguments, we too analyze this claim under an occupational disease theory.

In order to prove a compensable occupational disease, claimant must prove that work activities were the major contributing cause of a worsening of the underlying degenerative lumbar condition. ORS 656.802(1)(c); see Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991).

This case is sufficiently complex that medical causation must be established by medical experts. We conclude, as did the Referee, that neurologist Bell is claimant's attending physician. See ORS 656.005(12)(b) ("attending physician" means the physician who is primarily responsible for the treatment of a worker's compensable injury). Nonetheless, because resolution of this issue involves expert analysis rather than expert external observation, we do not give special deference to the attending physician's opinion. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979). Rather, when, as here, there is a dispute between medical experts, the 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 (1986); Hammons v. Perini Corp., supra.

Dr. Bell initially opined that claimant's work activity aggravated her asymptomatic preexisting degenerative condition causing her pain complaints, an opinion he reiterated in subsequent reports. Examining neurologist Wilson and orthopedic surgeon Neufeld, on the other hand, opine that work exposure was not the major contributing cause of any worsening of the preexisting degenerative changes. Based on x-ray and MRI findings showing lumbar facet joint sclerosis, these physicians attribute claimant's current condition to her preexisting degenerative condition.

At his deposition, Dr. Bell testified that claimant's work "aggravated, stirred up, and lit up" her "longstanding" degenerative condition. He explained that wearing a gunbelt aggravated the L4-5 joint, causing additional osteoarthritis, nerve root edema, and instability. Dr. Bell testified, however, that he had no objective evidence to support his conclusion; rather, he reached his conclusion based on historical information provided by claimant that wearing a gunbelt worsened her degenerative condition. Finally, Dr. Bell conceded that he did not know how heavy the gunbelt was or where claimant wore the gunbelt.

After reviewing the medical opinions, we find Drs. Wilson and Neufeld's opinion to be more persuasive because it is better reasoned and based on complete information. At his deposition, Dr. Neufeld persuasively explained that he and Dr. Wilson concluded that claimant's degenerative condition was not worsened by wearing the gunbelt because, while the gunbelt would put pressure on the pelvis, it would not cause any significant stress to the spine. In making this statement, Dr. Neufeld correctly noted that claimant did not sustain a discrete injury, but instead experienced the gradual onset of symptoms after wearing the gunbelt at work.

Contrary to the Referee, we do not find the opinion of Drs. Neufeld and Wilson to be inconsistent with the law of the case. First, although the employer accepted claimant's lumbar strain and L3-4, L4-5 disc bulges, it denied the compensability of claimant's degenerative condition. Drs.

Neufeld and Wilson have addressed only claimant's degenerative condition, not her accepted conditions. Their opinion that claimant's degenerative condition is not work-related is not inconsistent with the employer's acceptance of claimant's strain and disc bulges. Second, claimant testified that she did not sustain a low back injury as a result of any discrete event during her employment. Instead, she alleges only that her preexisting condition worsened over time as a result of wearing the gunbelt.

Because we find Drs. Wilson and Neufeld's opinion to be more persuasive, we conclude that claimant has not sustained her burden of proving an occupational disease claim. See Aetna Casualty Co. v. Aschbacher, supra. Alternately, because claimant's October 1988 injury is not the major contributing cause of her current low back degenerative condition, her claim is likewise not compensable under ORS 656.005(7)(a)(B). See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 24 (1993). Consequently, the employer's denial was proper. The Referee's order, insofar as it set aside the degenerative condition denial, is reversed. The Referee's award of an assessed attorney fee is also reversed.

Temporary Disability

We affirm and adopt the Referee's conclusions and reasoning, with the following comment. Claimant's hearing request as it pertains to this issue is reinstated. The relief sought is denied.

ORDER

The Referee's order dated November 25, 1992 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's denial of claimant's degenerative condition is reversed. The employer's denial is reinstated and upheld. That portion of the order that awarded a $2,750 assessed attorney fee is reversed. The remainder of the order is affirmed.

Board Member Gunn dissenting.

The majority upholds the employer's denial and, in the process, turns a blind eye to its own finding that the denial violated the statutory prohibition against back-up denials issued more than two years after claim acceptance. I dissent.

The record shows that in May 1989 the employer specifically and "officially" accepted claimant's injury claim for "lower back pain" resulting from wearing a gunbelt at work. After additional diagnostic studies and consultations were performed, it was determined that claimant's low back pain is due to a degenerative back condition which preexisted the industrial injury. In April 1992, more than two years after claim acceptance, the employer denied the degenerative back condition causing claimant's pain.

ORS 656.262(6) prohibits a carrier from revoking its prior claim acceptance more than two years after acceptance. Susie A. Fimbres, 44 Van Natta 1730, 1732 (1992), rev'd on other grounds Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). In addition, where a carrier accepts a symptom, it is deemed to have accepted the underlying disease causing the symptom. Georgia-Pacific v. Piwowar, 305 Or 494, 500 (1988).

Therefore, by specifically accepting claimant's low back pain, as a matter of law, the employer accepted the underlying degenerative disease causing the pain. Its back-up denial of that disease more than two years after acceptance is prohibited by ORS 656.262(6) and should be set aside as procedurally invalid.

Stated simply, the facts as we found them are established by the record. The law is clear on its face. I would adhere to our original order setting aside the employer's denial as an impermissible back-up denial. For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
RICHARD S. HOOKLAND, Claimant
Own Motion No. 92-0588M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of his February 12, 1968 compensable back injury. Claimant's aggravation rights expired on January 3, 1974. SAIF opposes reopening of claimant's claim on the ground that the proposed surgery is not reasonable and necessary.

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 teh time the worker is actually hospitalized or undergoes outpatient surgery. Id.

In its October 27, 1992 recommendation, SAIF asserted that the proposed surgery (repeat arthrodesis L4-5 with Luque plates and implantable bone stimulator) was not reasonable, necessary, or appropriate. On November 23, 1992, SAIF requested Medical Director review of the proposed surgery pursuant to ORS 656.327. On December 30, 1992, SAIF withdrew its request for review on the basis that the issue was being addressed through Caremark's (MCO) internal appeal process. On January 26, 1993, the Medical Director dismissed SAIF's request for review

On February 11, 1993, Caremark's Advisory Council upheld the disapproval of claimant's proposed surgery. The Council informed Dr. Matteri, claimant's attending surgeon, that if he disagreed with the decision, he could appeal it in writing within 30 days. There is no indication that Dr. Matteri appealed the Council's decision.

This record does not establish that the proposed surgery is reasonable and necessary. Instead, this issue appears to remain in controversy. Inasmuch as claimant has failed to establish that the proposed surgery is reasonable and necessary, the compensability of the proposed surgery has not been established. If the proposed surgery is subsequently determined to be reasonable and necessary treatment for his compensable back injury, claimant may again request own motion relief. However, until claimant proves that the proposed surgery is reasonable and necessary, he has failed to prove one the the elements necessary to authorize reopening of his claim for the payment of temporary disability compensation. ORS 656.278(1)(a)

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH E. RICKARD, Claimant
WCB Case No. 91-06676
SECOND ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

On February 17, 1994, we withdrew our January 25, 1994 Order on Remand which had set aside the insurer's denial of claimant's low back surgery and aggravation claims. We took this action to retain jurisdiction to consider the parties' proposed stipulation. Having received the parties' agreement, we proceed with our reconsideration.

The parties have submitted a proposed "Stipulation and Order of Dismissal," which is designed to resolve all issues raised or raisable in WCB Case No. 93-07518, a case which was pending before the Hearings Division. Pursuant to that stipulation, the insurer has rescinded its low back aggravation denial and agreed to process the claim commencing with the April 30, 1991 surgery in accordance with law. The stipulation has received Referee approval.

The parties have also submitted a joint request, seeking dismissal with prejudice of their respective appeals and without costs. In light of the stipulation and the joint request, we interpret the parties' intention to be that the stipulation shall be in lieu of all prior orders in this case. Since such a stipulation would also require Board approval, by this order we have approved the parties' agreement. See OAR 438-09-015(5).

Consequently, in accordance with the parties' joint request and the approved stipulation, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD E. SMITH, Claimant
WCB Case No. 92-10137
ORDER ON REVIEW
Olson Law Firm, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Referee Howell's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral hearing loss. On review, the issue is compensability.

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

Noting that claimant did not file claims for his hearing loss against his prior employers, the Referee reasoned that claimant had elected to prove that his hearing loss is compensably related to occupational noise exposure with this employer. The Referee also reasoned that claimant is not relying on the last injurious exposure rule to establish the compensability of his hearing loss. After reviewing the record, the Referee concluded that claimant has not sustained his burden of proof.

On review, claimant argues that, inasmuch as this employer failed to issue a notice of intent to disclaim responsibility under ORS 656.308(2) on the basis that occupational noise exposures with prior employers caused the hearing loss, he is not required to prove that noise exposure with this particular employer caused his hearing loss. Rather, he argues, he need only prove that occupational noise exposures with all of his employers caused his hearing loss.

We need not address claimant's argument because we conclude that claimant has not sustained the burden of proving a compensable occupational disease under Oregon law. We have previously held that, in order to establish the compensability of an occupational disease, a claimant must prove that his employment in Oregon was the major contributing cause of his condition or its worsening. Kevin P. Silveira, 45 Van Natta 1202, 1203 (1993).

Here, claimant was employed in Oregon as a police officer first in La Grande from 1972 until 1975 and then in Salem from 1975 to the present. Prior to 1972, claimant was not employed in Oregon. Rather, he was employed as a police officer in Idaho from 1969 until 1972. Before that, he worked about 10 months in Idaho on a utility company line crew, where he was exposed to high-level noise when operating the wood chipper. He also served in the U.S. Army where he was exposed to gunfire.

There is no evidence that claimant's Idaho employers employed workers in Oregon. Therefore, those employers were not "subject employers," see ORS 656.023, and their employment conditions may not be considered in our compensability determination. See Kevin P. Silveira, supra. Therefore, claimant must prove that his employment as a police officer in La Grande and Salem was the major contributing cause of his hearing loss condition. See ORS 656.802(1)(c), (2).

Given the multiple causal factors in claimant's hearing loss, we find that the causation issue is medically complex, requiring expert medical evidence to resolve. 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). For the reasons stated by the Referee, we are more persuaded by the opinion of Dr. Fairchild, than those of Drs. Frink and Eschelman. Dr. Fairchild effectively rebutted the other doctors' opinions that claimant's hearing loss was caused by noise to which he was exposed while employed as a police officer. Thus, we find no reliable medical evidence to prove that claimant's Oregon employments, as opposed to his employments elsewhere, were the major contributing cause of his hearing loss. Accordingly, his claim is not compensable.

ORDER

The Referee's order dated May 13, 1993 is affirmed.

In the Matter of the Compensation of
CARL R. ALATALO, Claimant
WCB Case No. 91-12629
ORDER ON REMAND (REMANDING)
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Alatalo v. Georgia-Pacific Corp., 123 Or App 627 (1993). The court has reversed our prior order, Carl R. Alatalo, 44 Van Natta 2097, on recon 44 Van Natta 2285 (1992), which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Reasoning that the Hearings Division had authority to consider a reconsideration order whether "invalid" or "valid," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact, as supplemented in our October 14, 1992 Order on Review.

CONCLUSIONS OF LAW AND OPINION

A January 15, 1991 Determination Order, as amended by a January 18, 1991 Determination Order, closed claimant's injury claim with an award of 27 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the right leg. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. In her request for reconsideration, claimant's attorney stated that claimant's treating physician did not participate in the claim closure and requested that a panel of medical arbiters be appointed to review the claim. (Ex. 60A). However, the Director apparently never appointed the requested panel.

The August 29, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Determination Order, as amended, in all respects. In addition, the Order on Reconsideration recognized that claimant was entitled to an examination by a medical arbiter and indicated that the Appellate Unit would schedule the claim for a medical arbiter review pursuant to ORS 656.268(7). (Ex. 62-1). Claimant requested a hearing regarding the Order on Reconsideration.

The Referee affirmed the Determination Orders and the Order on Reconsideration, and claimant requested Board review. In our prior order, we vacated the Referee's order. Carl R. Alatalo, supra. In doing so, we found that the Order on Reconsideration was invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, we concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

In Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court reversed the reasoning we used in deciding Olga I. Soto, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board."[1] Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Here, relying on its decision in Pacheco-Gonzalez v. SAIF, supra, the court has remanded our prior order for reconsideration. Accordingly, we proceed with our reconsideration.

The case was submitted to the Referee on the written record. Although the Referee admitted some exhibits into the record, a "post-reconsideration order" medical arbiter's report was not among them. In fact, the record neither supports a conclusion that a medical arbiter examination has occurred nor that a medical arbiter's report has been generated. In short, claimant's request for the appointment of a medical arbiter panel has gone unanswered.

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. ORS 656.295(5). Under the circumstances of this case, we find the record insufficiently developed. Moreover, in light of the court's recent decision in Pacheco-Gonzalez v. SAIF, supra, we find a compelling reason to remand. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993). Consequently, we remand this matter to the Referee for further evidence taking.[2] See Jimmy L. Holsapple, 46 Van Natta 67 (1994).

Accordingly, the Referee's order dated January 17, 1992 is vacated. We remand to Referee Livesley to conduct further proceedings in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7). Once these further proceedings are completed, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

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[1] Several arguments raised by the parties in their briefs on remand are resolved by the court's decision that the Hearings Division and the Board can and should review a medical arbiter's report not reviewed by the Department.

First, the self-insured employer argues that any medical arbiter's report may not be admissible because claimant's request for reconsideration was made prior to the effective date of the legislature's amendment to ORS 656.268(6)(a), which allowed any medical arbiter's report to be admitted as evidence at hearing even if not prepared in time for the reconsideration proceeding. Or Laws 1991, ch 502, §1. However, the court has ruled that "post-reconsideration" medical reports under former ORS 656.268(6)(a) are admissible. See Wickstrom v. Norpac Foods, Inc., 125 Or App 520 (1993).

Second, both parties note that neither the Hearings Division nor the Board has authority to remand a claim to the Department. Pacheco-Gonzalez v. SAIF, 123 Or App at 317. We agree. However, it is not necessary to remand this case to the Department for appointment of a medical arbiter. Also, contrary to claimant's argument, the Department need not reconsider its prior decision. Instead, the parties may request the Director to appoint a medical arbiter (or a panel of arbiters) and submit the arbiter's report to the Referee for consideration. See Linda M. Cross, 45 Van Natta 2130 (1993).

[2] As previously noted, the record is silent as to whether a medical arbiter examination has yet been performed and/or whether a medical arbiter report has been generated. Thus, the parties should make appropriate arrangements with the Director, if necessary. Thereafter, the assigned Referee should be contacted to continue with the proceedings. Linda M. Cross, supra.

In addition, in his appellant's brief on remand, claimant's attorney argues that this case should be remanded to the Hearings Division to allow claimant to submit additional evidence of impairment. In response, the employer argues that, if remand to the Hearings Division is ordered, any new evidence should be limited to a medical arbiter's report. Inasmuch as we are returning this case to the Referee, we decline to resolve this evidentiary issue. Instead, the parties may present their arguments and proposed exhibits to the Referee. In resolving any such evidentiary disputes, the Referee shall apply the principles expressed in Gary C. Fischer, 46 Van Natta 60 (1994), which provides an overview of the statutory limitations on evidence under ORS 656.245(3)(b)(B), 656.268(7), and 656.283(7).

March 4, 1994 Cite as 46 Van Natta 339 (1994)

In the Matter of the Compensation of
JANICE C. CORBETT, Claimant
WCB Case No. 92-10254
ORDER ON REVIEW
David C. Force, Claimant Attorney
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Referee Livesley's order which awarded claimant's counsel an assessed attorney fee of $6,000 for services rendered prior to SAIF's rescission of its denial of claimant's psychological condition. Claimant cross-requests review of the Referee's attorney fee award, and requests an increased attorney fee for services prior to hearing. In her brief, claimant also contends that the Board does not have jurisdiction over SAIF's request for review, as the Referee's reconsideration order became final and was not [illegible] SAIF [illegible]

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

On review, claimant apparently argues that we do not have jurisdiction over SAIF's request to reduce claimant's attorney fee award because SAIF did not appeal the Referee's order on reconsideration. We find claimant's argument to be without merit. The Referee's reconsideration order denied reconsideration. Therefore, the reconsideration order neither stayed, withdrew, modified, nor abated the prior order. Where a subsequent reconsideration order neither expressly or implicitly alters an initial order, we have held that the 30-day appeal period continues to run from the date of the original order. See Diana D. Couch, 41 Van Natta 834 (1989); Connie R. Walker, 40 Van Natta 84 (1988). (Where reconsideration order implicitly modified original order, 30-day rights of appeal runs from reconsideration order). Here, the Referee's Opinion and Order issued on June 30, 1993, and SAIF requested Board review on July 29, 1993, which was within the 30 day period to request review. ORS 656.289(3). Therefore, we have jurisdiction to consider SAIF's request.

Because the only issue on review concerns attorney fees, no fee is available for claimant's counsel's services on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 30, 1993 is affirmed.

March 4, 1994 Cite as 46 Van Natta 340 (1994)

In the Matter of the Compensation of
CORNELL D. GARRETT, Claimant
WCB Case No. 92-15915
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Priscilla Taylor, Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Hall.

The insurer requests review of Referee Barber's order that increased claimant's award of unscheduled permanent disability for a back injury from 3 percent (9.6 degrees), as awarded by Order on Reconsideration, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the ultimate findings of fact and with the following supplementation.

The most appropriate DOT for claimant's at-injury job as a pressure washer is Cleaner II (any industry) (DOT# 919.687-014). The DOT describes this job as a medium strength job.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 3 percent, as awarded by Order on Reconsideration, to 18 percent. We reverse.

The parties have stipulated to the values for age (1), formal education (0), training (1), skills (3), and impairment (3). Thus, the only dispute between the parties concerning the unscheduled award is the correct value for the adaptability factor.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made

Claimant became medically stationary on June 9, 1992, and her claim was closed by Notice of Closure on June 30, 1992. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the Notice of Closure. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 6-1992. The "standards" in effect on the date of the June 30, 1992 Notice of Closure apply. WCD Admin. Order 6-1992.

In determining the extent of permanent disability, the adaptability factor is a comparison of the highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination, as compared to the worker's maximum residual capacity at the time of determination Former OAR 436-35-310(1). For a job to qualify, the worker must meet the requirements as outlined in OAR 436-35-300(3). See former OAR 436-35-270(3)(g). The requirements listed in OAR 436-35-300(3) include identification of the DOT Code which most accurately describes the duties of each job and meeting the Specific Vocational Preparation (SVP) category assigned by the DOT. See former OAR 436-35-300(3).

In the ten years preceding the time of determination, claimant's most physically demanding jobs were as a highway maintenance worker (DOT# 899.684-014) and his at-injury job as a pressure washer (Cleaner II (any industry) (DOT# 919.687-014). Both occupations are described by the DOT has a medium strength job. The Referee concluded that claimant was capable of medium work. However, based on claimant's testimony, the Referee found that claimant's at-injury job was in the heavy category. On this basis, the Referee found that claimant's adaptability factor was 3 (heavy to medium). We disagree.

We consider the record as a whole, including the job duties and the physical demands of the relevant job, in determining which DOT is most applicable. Nevertheless, the fact remains that the most applicable DOT determines the strength category. See former OAR 436-35-300(3); 436-35-270(3)(g); William D. Knox, 45 Van Natta 854 (1993). Claimant's testimony is relevant to the determination of which DOT most accurately describes his at-injury job. Kathyron D. Parsons, 45 Van Natta 954 (1993). However, claimant's testimony may not be relied upon to determine that no DOT description accurately describes his job, and that, therefore, his strength category must be determined without regard to the DOT. Id.

Here, claimant does not contend that the DOT job description as a Cleaner II (any industry) assigned by the Order on Reconsideration is inaccurate. Rather, he contends that the job required him to perform work that was more appropriately described as heavy. We do not find claimant's contention persuasive. As stated above, the strength requirement for claimant's job must be determined by the DOT job description. Claimant has not submitted, and we have not found, a DOT job description that is more appropriate for claimant's work than as a pressure washer.

OAR 436-35-310(2) provides that workers who have the residual functional capacity for their regular work receive an adaptability value of zero (0). Since claimant's regular work was in the medium category and since the record establishes and claimant concedes that he has been released to return to medium work, his value for adaptability is 0.[1]

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (5) is multiplied by the adaptability value (0), the total is 0. When this value is added to the value for impairment (3), the result is 3. Therefore, claimant's unscheduled permanent disability under the "standards" is 3 percent.

ORDER

The Referee's order dated April 1, 1993 is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety.

Board Member Hall dissenting.

For the reasons set forth in the dissent in Michelle Cadigan, 46 Van Natta 307 (1994), I dissent in this case.

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case Nos. 92-11012 & 92-10411
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our February 4, 1994 Order on Review that awarded an assessed attorney fee of $150 for claimant's counsel's services in obtaining a pre-hearing rescission of the SAIF Corporation's "de facto" denial of claimant's adhesive capsulitis condition. Contending that our attorney fee award does not provide adequate compensation for her counsel's efforts, claimant seeks a $750 attorney fee.

In order to further consider this matter, we withdraw our February 4, 1994 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be received within 14 days from the date of this order. Claimant's reply, if any, shall be due 14 days from the date of mailing of SAIF's response. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTINE L. HOOMES, Claimant
WCB Case No. 91-11232
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Garaventa's order which dismissed her hearing request on the basis that her refusal to submit to an independent medical examination caused an unjustified delay in the hearing of more than 60 days. On review, the issue is dismissal.

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

We begin with a brief summary of the facts. Claimant has filed a mental stress claim alleging sexual harassment at work. The SAIF Corporation denied the claim, and claimant requested a hearing. At SAIF's request, claimant attended an IME performed by psychiatrist Dr. Glass on November 29, 1991. However, claimant failed to attend a second IME that SAIF scheduled with Dr. Turco on two occasions, in January and February 1992. In February 1992, claimant's attending physician Dr. Green wrote that claimant is unable to attend further workers' compensation evaluations "due to risk of exacerbation of her stress disorder and immune dysfunction." He added that "further stresses may cause her substantial injury." (Ex. 18).

Meanwhile, the hearing on claimant's stress claim, which was originally scheduled for November 12, 1991, was placed in deferred status pending a release from Dr. Green for claimant to attend the IME. On March 20, 1992, Dr. Green wrote: "I feel [claimant] will be harmed by further pursuit of this case, due to the inordinate amount of stress involved. She has a fragile immune system and a lot of fear about further harm, which is not totally unfounded." (Ex. 4-2). On June 2, 1992, Dr. Green reported no change in claimant's situation. (Ex. 4-3).

Claimant's counsel subsequently withdrew from the case. On August 26, 1992, claimant wrote the Referee that she would like to "proceed with a hearing." (Ex. 11). SAIF responded that the case should remain in deferred status until claimant attends the IME.

A hearing was convened on February 26, 1993, at which claimant appeared with counsel. At that time, claimant requested to proceed to a hearing on the merits of her claim. SAIF moved to dismiss the hearing request for claimant's failure to attend the IME. The Referee granted the motion.

Claimant contends that the Referee erred in dismissing her hearing request because she was following her attending physician's advice in refusing to attend the independent medical examination (IME) requested by the SAIF Corporation. Contending that her attendance at the IME would be detrimental to her psychological condition, claimant argues that SAIF's request for an IME is unreasonable.

ORS 656.325(1) provides, in pertinent part:

> "Any worker entitled to receive compensation under this chapter is required, if requested by * * * the insurer * * *, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. However, no more than three examinations may be requested except after notification to and authorization by the director." (Emphasis supplied).

Under this statute, claimant is required to attend up to three IME's that may be requested by the insurer. The Director's rules also provide, however, that "[s]uch examinations...shall not delay or interrupt proper treatment of the worker." OAR 436-10-100(4). Our first inquiry, therefore, is to determine whether the IME requested by SAIF would delay or interrupt claimant's proper treatment. Based on our review of the record, we do not find that it would.

It is clear from Dr. Green's notes in the record that he believes further "pursuit" of the stress claim would subject claimant to an inordinate, and potentially injurious, amount of stress. Claimant contended at hearing, and maintains on review, that Dr. Green intended to excuse claimant from attending the IME only, not the hearing. We disagree. Dr. Green's March 20, 1992 note is phrased broadly to advise claimant against "further pursuit of this case." We believe Dr. Green is advising claimant not to pursue litigation of her claim. Our interpretation is consistent with the fact that litigation is an adversarial process which can subject parties to considerable stress. In fact, an adversarial hearing can be much more stressful than a medical examination, particularly where at hearing, the party must listen to witnesses testifying against her, and submit to the rigors of cross-examination.

Yet, notwithstanding her physician's advice, claimant wishes to proceed to a hearing on the merits of her claim. At the same time, claimant seeks to avoid the IME, claiming that it would be detrimental to her condition. Claimant's position is internally inconsistent. As the Referee observed, claimant cannot rely on her physician's advice to avoid the IME, but at the same time, ignore his advice not to pursue her case at hearing. That would contravene the statutory requirement that claimant submit to IME's requested by SAIF. In view of claimant's intention to proceed with her case at hearing, despite her physician's advice, we do not find that the IME requested by SAIF would delay or interrupt claimant's proper treatment. Indeed, by deciding to pursue the case, it is claimant who may be delaying or interrupting proper treatment.

ORDER

The Referee's order dated March 2, 1993 is affirmed.

In the Matter of the Compensation of
SANDRA K. JONES, Claimant
WCB Case No. 93-02735
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Daughtry's order that awarded claimant 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of each foot, whereas an Order on Reconsideration awarded 15 percent (20.25 degrees) for each foot. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that OAR 436-35-200(4) provides for an impairment value for disability resulting from an injury, but does not apply to disability resulting from an occupational disease. On review, claimant contends that the rule pertains to disability resulting from either an injury or an occupational disease. We agree.

A Determination Order awarded claimant 5 percent, bilaterally, for her chronic foot condition. On reconsideration, the Appellate Unit applied OAR 436-35-200(4), and increased claimant's scheduled permanent disability award. OAR 436-35-200(4) provides that:

> "When a preponderance of objective medical evidence indicates an accepted compensable injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period, the award shall be 15 percent of the foot. This value is combined with all other scheduled impairment findings in the foot. A worker who is entitled to receive impairment under OAR 436-35-230(6) or (7) shall not be allowed additional impairment under this rule. This rule is applicable in those cases where the objective medical evidence indicates severe injury to the foot has occurred with residual impairment (e.g. severe soft tissue crush injuries, calcaneal fractures, or post-traumatic avascular necrosis)." (Emphasis added).

The self-insured employer contends that the aforementioned rule is not applicable because claimant's accepted condition consists of an occupational bone spur disease. The employer argues that the Department's rule applies only to industrial injuries as provided for by the specific language of the rule.[1]

We do not find support for the narrow construction of the rule advanced by the employer. 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. ORS 656.214(2). Subject to exceptions not relevant here, an occupational disease is considered an injury for employees of employers who have come under Chapter 656. ORS 656.804.

The "standards" define scheduled disability as a permanent loss of use or function which results from injuries to the body parts listed in ORS 656.214(2)(a) through (4). OAR 436-35-005(7). The standards further provide that scheduled permanent disability is rated on the "permanent loss of use or function of a body part due to an on-the-job injury." OAR 436-35-010(2).

We conclude that, although the standards refer to an "injury," the term "injury" is used in its broadest sense, and includes impairment arising from occupational diseases. For example, the "General Principles for Rating Disability" section of the standards provides, in part:

> "(1) A worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions." OAR 436-35-007(1). (Emphasis added).

Although the general principles refer only to an injury, it is clear that impairment values are awarded for disability arising from occupational diseases such as cardiovascular disease, OAR 436-35-380, respiratory impairment, OAR 436-35-385, and mental illness, 436-35-400. Additionally, the standards providing for scheduled impairment provide impairment values for conditions such as visual loss (OAR 436-35-260), hearing loss (OAR 436-35-250), and skin disorders (OAR 436-35-230(5). Thus, although the standards refer to an on-the-job "injury," awards for impairment are, nevertheless, available for loss of use or function which arise as a result of a injury or an occupational disease. Each of these administrative rules is consistent with the legislative intentions envisioned in ORS 656.214(2) to rate disability based on the permanent loss of use or function of the injured body part and ORS 656.804 to treat occupational diseases as injuries.

Finally, in examining the rule at issue, OAR 436-35-200(4), we note that the rule provides for impairment value when the impairment results from calcaneal fractures or avascular necrosis. We find no reason to distinguish between a fracture or necrosis condition that results from a discrete injury, and the same impairment which is caused over a period of time as the result of an occupational disease. Moreover, OAR 436-35-200(4) provides that a claimant who is entitled to receive impairment under OAR 436-35-230(6) or (7) shall not be allowed additional impairment under the rule. OAR 436-35-230(6) pertains to vascular disease. Consequently, because the drafters of the rule referenced another rule pertaining to occupational disease, we find it consistent to interpret OAR 436-35-200(4) as also allowing impairment awards for disability resulting from occupational disease.

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[1] Board Member Gunn would hold that if we adopted the employer's interpretation, we are still left with a claimant with an impairment not addressed by the standards which would require remand under Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

More importantly, however, because scheduled permanent disability is based on permanent loss of use or function of a body part, we conclude that, if claimant has established such a loss and the impairment is rated under the standards, it is not relevant whether the disability has resulted from an industrial injury or an occupational disease.

Based on the above reasoning, we find no reason to preclude claimant from an award under OAR 436-35-200(4) solely on the basis that her impairment has resulted from an occupational disease, rather than an industrial injury. We therefore proceed to determine whether claimant has established entitlement to such an award.

Claimant's accepted occupational disease claim has been described by her attending physician, Dr. Walton, M.D., as a "painful condition in both feet due to bone spur formation in multiple areas." As a result of her condition, Dr. Walton permanently restricted claimant to sedentary work, with walking or standing for one hour in an eight hour workday.

Accordingly, we conclude that the medical evidence indicates that claimant's accepted bone spur formation condition has resulted in a permanent inability to walk or stand for greater than two hours in an eight hour period. See OAR 436-35-200(4). Furthermore, based on Dr. Walton's permanent restrictions and his description of claimant's painful condition which exists in both feet in multiple areas, we find that the medical evidence indicates that claimant's foot condition is severe and has resulted in residual impairment. Therefore, claimant is entitled to an award of 15 percent scheduled permanent disability for each foot. OAR 436-35-200(4).

Dr. Walton also reported that claimant could not use her feet for repetitive movements, such as operating foot controls. Consequently, we conclude that claimant has established that she is unable to repetitively use her feet due to a chronic and permanent medical condition. Therefore, claimant is entitled to an award of 5 percent scheduled permanent disability for each foot. OAR 436-35-010(6).

Claimant's impairment awards of 15 percent and 5 percent are combined for a total scheduled impairment award of 19 percent for each foot. OAR 436-35-010(6)(c).

ORDER

The Referee's order dated June 23, 1993 is modified. In lieu of the Referee's award and in adition to the Order on Reconsideration award of 15 percent (20.25 degrees) scheduled permanent disability for each foot, claimant is awarded 4 percent (5.4 degrees), for a total award to date of 19 percent (25.65 degrees) scheduled permanent disability for each foot. Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $3,800.

In the Matter of the Compensation of
CARL R. MARTINEZ, Claimant
WCB Case No. 92-16543
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

The SAIF Corporation requests review of Referee Black's order that assessed an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable processing of claimant's physician's request for qualification under the "primary care physician" exception to the managed care organization (MCO) contract. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his finding that SAIF's November 18, 1992 letter was a "prospective denial" of compensation. We also make the following supplemental findings.

Claimant has an accepted claim for a musculoligamentous injury sustained in March 1992. Although the claim was initially accepted as nondisabling, it was reclassified as disabling on November 5, 1992. Meanwhile, claimant was treating with Dr. Brandt, his longtime family physician, for the effects of his industrial injury.

On November 18, 1992, Ms. Wade, SAIF's claims adjuster, wrote claimant a letter explaining that SAIF had entered into an agreement with Caremark Comp, a state-certified MCO, to provide medical services to injured workers. The letter also advised that claimant had qualified for enrollment into the MCO program and, therefore, he must receive care from either a Caremark Comp physician or a family physician meeting certain conditions and qualifications. The letter continued:

> "In the meantime, we have determined that the medical care you are seeking from Gary Brandt, M.D. cannot be reimbursed by SAIF because this provider is not a member of Caremark Comp and does not qualify under the family physician exception. By copy of this letter, I am also notifying Gary Brandt, M.D. that any further treatment will not be paid by SAIF. IN ORDER FOR YOUR FUTURE MEDICAL SERVICES ARISING FROM THIS CLAIM TO BE REIMBURSED, YOU MUST SEEK TREATMENT FROM A CAREMARK COMP AUTHORIZED PROVIDER OR A FAMILY PHYSICIAN AS DESCRIBED ABOVE. * * * * *" (Ex. 2).

After receiving a copy of the letter, Dr. Brandt called Ms. Wade on December 8, 1992, requesting her assistance in processing his certification as claimant's primary care physician. (Tr. 13). Ms. Wade agreed and, on the following day, sent a letter to Caremark Comp stating, in relevant part: "[Claimant] is seeking care from a provider who qualifies as a Primary Care Physician. Please initiate the Caremark Comp certification process and inform me when the process is completed." (Ex. 3). Ms. Wade also sent a letter to claimant's counsel advising that she had requested "primary care physician" qualification for Dr. Brandt.

Claimant filed a request for hearing concerning the November 18, 1992 letter, asserting that SAIF had "de facto" denied claimant's medical services claim. Claimant did not seek further treatment with Dr. Brandt after receiving the November 18 letter. Instead, he has sought treatment as needed through an emergency room. (Tr. 7-8).

At the time of the March 24, 1993 hearing, there was no indication that Dr. Brandt had been certified as a primary care physician by Caremark Comp. There also was no evidence of unpaid medical bills for claimant's treatment by Dr. Brandt or through the emergency room.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, SAIF argues that neither the Referee nor the Board has jurisdiction of the medical service dispute, citing Stanley Meyers, 43 Van Natta 2643 (1991). Subsequent to the Referee's order, the Court of Appeals reversed our decision in Meyers. Meyers v. Darigold, Inc., 123 Or App 217 (1993).

In Meyers, the court held that the 1990 amendments to ORS 656.327(1) do not require the parties or the Director to invoke the Director review process. Rather, the court determined that if a party or the Director "wishes review of the treatment by the director," and gives notice, the statute provides the procedure for a proceeding, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. Without a "wish" for Director review and a notice filed with the Director, the court further concluded that there is no "proceeding" before the Director. Reasoning that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create the jurisdiction occur, the court held that those conditions did not occur in Stanley Meyers. Accordingly, the court found that the medical treatment dispute remained within the Board's jurisdiction.

Here, there is no evidence that either the parties or the Director "wished" for Director review or filed notice with the Director for such a review. Instead, claimant filed a request for hearing. Under such circumstances, we conclude that the Director did not have exclusive jurisdiction over this matter and that the Referee was authorized to consider the dispute. See Meyers v. Darigold, Inc., supra.

The Referee interpreted SAIF's November 18, 1992 letter as a "prospective denial" of future treatment by Dr. Brandt, and set it aside as procedurally invalid under Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). We disagree.

In Striplin, the court set aside a denial which purported to deny "all further chiropractic care" as not reasonable and necessary for the compensable injury. The court held that, although a carrier has authority to deny a current claimed need for medical services, it may not deny its future responsibility for payment of benefits relating to a previously accepted claim, unless it follows the statutory procedure for claim closure. Id. at 356-57. See also Green Thumb, Inc. v. Basl, 106 Or App 98 (1991) (Denial of current need for treatment is not a prospective denial.)

In this case, we do not interpret SAIF's November 18, 1992 letter as a denial of future responsibility for medical services related to the compensable injury. Rather, we interpret the letter as a notification to claimant that Dr. Brandt did not qualify either as a Caremark Comp physician or under the "primary care physician" exception to the MCO contract between SAIF and Caremark Comp.[1] In so notifying claimant, SAIF was fulfilling its statutory duty under ORS 656.245(5), which provides, in relevant part:

> "Notwithstanding paragraph (a) of subsection (3) of this section [which grants workers the right to choose an attending physician], when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provided to injured workers, those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. * * * * Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical services providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe." (Emphases supplied).

Under this provision, claimant must receive medical services in the manner provided by the MCO contract. Further, SAIF was required to notify claimant that Dr. Brandt is not an eligible medical service provider under the contract. This was the clear intent of the November 18, 1992 letter. Hence, we do not interpret the letter as a denial of future medical services for the compensable injury. Our conclusion is supported by the absence of evidence of any outstanding medical bills for claimant's treatment, including treatment he sought through the emergency room following receipt of SAIF's letter.

After receiving the November 18 letter, Dr. Brandt contacted SAIF on December 8, 1992, and apparently supplied information about his qualifications as a primary care physician. The next day, SAIF acted promptly in forwarding the information to Caremark Comp for processing. Although there is no indication that Caremark Comp had completed processing the qualification request as of the March 24, 1993 hearing, we find no basis for assessing a penalty-related attorney fee under ORS 656.382(1).

ORS 656.382(1) provides, in relevant part, that "[i]f an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant a reasonable attorney fee. . . ." Because this provision specifically addresses unreasonable conduct by an insurer or employer, and it does not mention MCO's, it is arguable whether ORS 656.382(1) authorizes the assessment of an assessed fee against the insurer based on an MCO's unreasonable resistance to compensation.[2]

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[1] The Director's rules provide that, in order to qualify under the "primary care physician" exception, a physician must: (1) qualify as an attending physician and must be a general practitioner, a family physician, or an internal medicine specialist; (2) maintain the worker's medical records; (3) have a documented history of treatment of that worker; (4) agree to comply with all terms and conditions regarding services governed by the MCO; and (5) agree to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require. OAR 436-15-070(1). There is no evidence that, at the time of its November 18, 1992 letter, SAIF had sufficient information from which to conclude that Dr. Brandt had complied with all five requirements under this rule. Therefore, SAIF reasonably concluded that Dr. Brandt did not qualify as a "primary care physician."

[2] We note that the Director is authorized to impose sanctions, including civil penalties, against an MCO if it violates OAR 436-15-070. See OAR 436-15-120(1). Subsection (1) of OAR 436-15-070 provides that the MCO "shall authorize a physician who is not a member of the MCO to provide medical services to a worker at time of injury if the physician qualifies as a primary care physician."

We need not address that question in this case, however, because we are not persuaded that either SAIF or Caremark Comp unreasonably resisted the payment of compensation. In this regard, we note that, as the proponent of an assessed fee under ORS 656.382(1), claimant has the burden of proving that SAIF or Caremark Comp unreasonably resisted the payment of compensation. See Lisa L. Ross, 40 Van Natta 1962, 1964 (1988) (citing Harris v. SAIF, 292 Or 683, 690 (1982)).

Here, we find that SAIF acted promptly in forwarding information concerning Dr. Brandt's qualifications to Caremark Comp. It is not apparent from the record why Dr. Brandt had not been qualified as a "primary care physician" by the time of the March 24, 1993 hearing. The Director's requirements for "primary care physician" qualification include two conditions to which the physician must agree: (1) agree to comply with all terms and conditions regarding services governed by the MCO; and (2) agree to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require. OAR 436-15-070(1)(d) and (e). If the physician does not agree to these terms, the physician may not qualify under the "primary care physician" exception to the MCO contract.

There is no evidence in the record showing that Dr. Brandt has agreed to comply with all terms and conditions regarding services governed by the MCO or that he agreed to refer the worker to the MCO for specialized care. Under these circumstances, therefore, we conclude that claimant has not sustained his burden of proving that either SAIF or Caremark Comp unreasonably resisted the payment of compensation. Accordingly, a penalty-related attorney fee may not be assessed under ORS 656.382(1).

ORDER

The Referee's order dated April 23, 1993 is reversed.

In the Matter of the Compensation of
PATRICIA D. RANDLE, Claimant
WCB Case No. 93-00308
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Garaventa's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

The Referee discounted the opinion of Dr. Becker, orthopedic surgeon, on the ground that he did not offer an opinion regarding the cause of claimant's CTS. We agree.

We also find Dr. Becker's opinion unpersuasive because it was based on an inaccurate history. Dr. Becker reports that claimant first became symptomatic at work. (Ex. 12). Because that history conflicts with claimant's admission that she first became symptomatic at night (Exs. 3, 5; Tr. 5), Dr. Becker's opinion is entitled to minimal, if any, probative weight. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Becker also stated that he was unable to discern any other possible etiology for claimant's condition. However, claimant cannot meet her burden of proof simply by disproving other potential causes of her CTS, ORS 656.266, Robin G. Rothe, 45 Van Natta 369 (1993). Therefore, without more in the way of supportive evidence, we cannot give this reasoning of Dr. Becker substantial weight.

Finally, we address an argument raised by claimant regarding her theory of compensability. In her opening brief, claimant asserts that, "Where the symptoms are the disease, the Board has found carpal tunnel to be compensable. Georgia Pacific v. Warren, 103 Or App 275 (1990)." (Claimant's Brief at 3). We understand claimant to be arguing that a worsening in her symptoms is enough to meet her burden of proof. We disagree.

A claimant may prevail on an occupational disease claim by establishing that her employment conditions were the major contributing cause of the disease or its worsening. ORS 656.802(2). Ordinarily, the claimant must establish a pathological worsening of her underlying condition, not merely a symptomatic worsening. See Weller v. Union Carbide Corp., 288 Or 27 (1979). If, however, the medical evidence establishes that the claimant's symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions, will be compensable. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990).

We disagree with claimant's argument for two reasons. One, no medical opinion addresses the issue of whether claimant's symptoms are her disease. Two, the evidence establishes that many of claimant's complaints were not related to her work activities. (See Exs. 3, 5; Tr. 5). Accordingly, we do not find persuasive claimant's "worsened symptoms" theory of compensability.

ORDER

The Referee's order dated June 28, 1993 is affirmed.

In the Matter of the Compensation of
CALVIN J. CLINGENPEEL, Claimant
WCB Case No. C4-00092
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Liberty Northwest, Insurance Carrier

Reviewed by Board Member Neidig and Hall.

On January 11, 1994, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury. As the disposition complied with statutory requirements and applicable administrative rules, we approved the agreement on February 11, 1994.

On February 22, 1994, we received an "Addendum to Claim Disposition Agreement" stating that it has been further agreed by the parties that the insurer will pay claimant the balance of permanent partial disability owing. Because the CDA has been approved, we treat the parties' submission as a request for reconsideration of the CDA.

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, the approved CDA was mailed to the parties on February 11, 1994, and claimant's request for reconsideration was received by the Board on February 22, 1994. However, the 10th day after the February 11, 1994 CDA was Monday February 21, 1994, a legal holiday. Thus, we find claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2). Moreover, upon review of the addendum, we find good cause for allowing the additional submission. Accordingly, we will reconsider this CDA. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

The parties have submitted an addendum to the disposition that specifically provides for payment of previously unpaid permanent partial disability, in addition to the total amount due claimant as stated in the original agreement. On reconsideration, we find that this agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. Furthermore, because this agreement has previously been approved, and the modified agreement does not provide for less consideration then the original agreement, we do not consider the modified agreement a new CDA requiring an additional 30 days in which claimant may request disapproval. See Reginald C. Norbury, 45 Van Natta 2407 (1993); Mary A. Smith, 45 Van Natta 1072 (1993). Thus, we do not find any statutory basis for disapproving the modified agreement. See ORS 656.236(1). Accordingly, on reconsideration, the claim disposition is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS A. HUTCHESON, Claimant
WCB Case No. 93-01912
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Menashe's order that: (1) found that claimant's low back claim was not prematurely closed; (2) declined to grant permanent total disability; and (3) affirmed an Order on Reconsideration that did not award unscheduled permanent disability. The insurer cross-requests review of that portion of the Referee's order that declined to authorize an offset of the insurer's alleged overpayment of temporary disability benefits. On review, the issues are premature closure, permanent total disability and offset. We affirm.

FINDINGS OF FACT

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

In May 1991, Drs. Neufeld and Wilson examined claimant on the insurer's behalf, and concluded that claimant had low back strain, by history, and spondylolysis, L5 on the left, by CT report. (Ex. 16-5). They did not feel that claimant was medically stationary at that time. However, in a later report dated October 4, 1991, they concluded that, on the basis of their review of additional records, claimant's lumbar strain had become medically stationary. (Ex. 22).

On October 14, 1991, Dr. Zivin, another examining physician, also concluded that it would be reasonable to expect that claimant's October/December 1990 lumbar strain would have resolved in several days, because he had had rapid recoveries from previous back strains. (See Ex. 23).

On December 5, 1991, Dr. Thompson examined claimant on behalf of the insurer. (Ex. 30). Dr. Thompson concluded that, because claimant's condition had not changed appreciably for several months before the examination, claimant's lumbar strain was probably medically stationary. (Id. at 6).

Thereafter, claimant's treating physician, Dr. Nash, reported that claimant needed a lumbar laminectomy and therefore, was not yet medically stationary. (Ex. 31-1). Nash opined that the major contributing cause of claimant's ongoing problem was a nerve root entrapment caused by a recurrent prolapsed disc at L4-5. (Id). Nash performed the surgery on April 28, 1992. (Exs. 35B, 35C).

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's conclusions regarding premature closure, with the following supplementation.

Claimant sustained his compensable lumbar strain in October and December 1990; at the time, he also had a noncompensable preexisting degenerative disc condition. The insurer accepted the lumbar strain and denied the preexisting degenerative disc condition. The denial was upheld on appeal. See Thomas A. Hutcheson, 44 Van Natta 2405 (1992).

On December 5, 1991, Dr. Thompson examined claimant on the insurer's behalf. After conducting an extensive review of claimant's medical history, current symptoms and radiological data, Dr. Thompson opined that, because claimant's physical condition had been essentially unchanged for several months, claimant was medically stationary. (Ex. 30).

Claimant began treating with Dr. Nash in March 1991. Dr. Nash diagnosed a prolapsed disc at L4-5 that he felt required surgical intervention. Nash performed a lumbar laminectomy on April 28, 1992. Thereafter, claimant continued to have back pain. Drs. Nash and Misko diagnosed lumbar instability, and recommended further surgery. (Exs. 35D, 35K, 36).

Claimant's lumbar strain claim was closed by Notice of Closure on November 3, 1992. The Notice of Closure awarded claimant temporary disability compensation and a 15 percent (48 degrees) unscheduled permanent disability award. The permanent disability award was reduced to zero by a February 5, 1993 Order on Reconsideration.

Claimant requested a hearing on the Order on Reconsideration, and raised the issues of premature closure and extent of permanent disability. The insurer sought an offset for overpaid temporary disability benefits. The Referee affirmed the Order on Reconsideration and declined to authorize an offset.

On review, claimant argues that, because the opinions of Drs. Nash and Misko reveal that he is not yet medically stationary, his lumbar strain claim was prematurely closed. We disagree.

A claim shall not be closed if a worker's compensable condition has not become medically stationary. ORS 656.268(1). That a worker also has a noncompensable condition that is not medically stationary at the time of claim closure does not preclude a finding that the worker's compensable condition is medically stationary. See Diane T. Dawes, 44 Van Natta 90 (1992). The proper inquiry is whether, as to the worker's compensable condition, any material improvement can reasonably be expected from either medical treatment or the passage of time. See ORS 656.005(17).

As did the Referee, we rely on the opinion of Dr. Thompson, and conclude that claimant's compensable lumbar strain was medically stationary on December 5, 1991. Dr. Thompson's opinion is well-reasoned and is based on a complete and accurate history. See Somers v. SAIF, 77 Or App 259, 263 (1986). Moreover, as the Referee points out, Dr. Thompson's opinion is in accord with earlier examining physicians' reports that support the conclusion that claimant's lumbar strain was medically stationary by December 5, 1991. (See Exs. 22, 23).[1]

The opinions of Drs. Nash and Misko do not alter our conclusion. Although we ordinarily defer to the opinions of a claimant's treating physicians, we find persuasive reasons not to do so here. Weiland v. SAIF, 64 Or App 810 (1983).

Drs. Nash's and Misko's reports focus on claimant's noncompensable degenerative disc condition, with an emphasis on his L4-5 disc herniation. (See Exs. 31-1, 35K, 38, 38A). Neither doctor specifically addresses the status of claimant's compensable lumbar strain. Accordingly, we conclude that because Drs. Nash and Misko failed to distinguish between claimant's compensable and noncompensable back conditions, their opinions are entitled to little weight. See Diane T. Dawes, supra. This conclusion is bolstered by Dr. Nash's January 1992 report that stated that claimant's (noncompensable) recurrent disc protrusion was the major contributing cause of claimant's continued back problems. (See Ex. 31-1).

For these reasons, we agree with the Referee's conclusion that claimant's lumbar strain claim was not prematurely closed.

Extent of Permanent Disability

We adopt the Referee's conclusions regarding extent of permanent disability, with the following supplementation.

Claimant contends that he is permanently and totally disabled. He argues that the preponderance of competent medical evidence establishes that he is unable to engage in any gainful or suitable employment. See ORS 656.206(1)(a). We disagree.

To prove entitlement to permanent total disability, claimant must establish that he is permanently unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant has not met his burden of proof.

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[1] Claimant argues that Dr. Thompson's report is not probative of his medically stationary date because the report states that claimant does have some impairment because of his work injuries and that, in December 1991, claimant had yet to return to his pre-injury status. (See Ex. 30-6, -7.) That argument is not persuasive, because the existence of an impairment does not

The only evidence in the record that concerns claimant's supposed permanent inability to work is a concurrence letter from claimant's counsel to Dr. Nash that states:

> "You indicated that in your professional medical opinion [claimant] has been unable to engage in any gainful or suitable employment on a regular basis since you began treating him on March 11, 1991. Though he has improved since his low back surgery, it is your opinion that he remained totally incapacitated from regular and suitable employment when you last saw him on October 1, 1992." (Ex. 37-1).

That evidence does not suffice to meet claimant's burden of proof under ORS 656.206(1)(a). Dr. Nash does not opine that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. In any event, we conclude that, in the absence of other persuasive evidence, the simple recitation of the applicable statutory language is not enough to meet claimant's burden. See Debra L. Godell, 45 Van Natta 34 (1993).

The Referee correctly concluded that claimant has failed to establish that he is permanently and totally disabled.[2]

Offset

The insurer claims a $14,897.29 overpayment of temporary total disability benefits paid from December 6, 1991 through October 18, 1992. The only evidence that the insurer submitted regarding its offset claim was its counsel's oral representations at hearing regarding the time period during which the alleged overpayments were made and the total of the overpayments. (Tr. 4-6).

The Referee concluded that, because the insurer had failed to present sufficient evidence concerning the existence and amount of the overpayment, the insurer was not entitled to an offset. On review, the insurer argues that, because claimant did not dispute its counsel's oral representations regarding the amount of overpayment, under Francis I. Bowman, 45 Van Natta 500 (1993), it is entitled to an offset. We disagree.

A referee may authorize an offset for overpaid temporary disability benefits if the carrier establishes its entitlement to a particular amount of overpayment by a preponderance of the evidence. Metro Machinery Rigging v. Tallent, 94 Or App 245, 248 (1988); Maxine Headley, 45 Van Natta 1213 (1993). In the absence of rebuttal evidence, a carrier can satisfy that burden by submitting evidence that: (1) shows how the payments of compensation were made; and (2) sets forth the method of calculating the claimed overpayment. Allen L. Frink, 42 Van Natta 2666 (1990).

In Francis I. Bowman, supra, we applied these principles and concluded that the carrier was entitled to an offset. The claimant had been notified by an audit letter that she had been overpaid temporary disability benefits for a particular time period; the letter also specified the precise amount of the claimed overpayment. At hearing, the claimant did not testify that she had never received the payments, or that the carrier's requested offset had been miscalculated. Id. at 502. Under the circumstances, we concluded that the carrier had presented sufficient evidence for an offset. Id.

This case is distinguishable from Bowman. Here, with the exception of the insurer's counsel's oral representations regarding the purported overpayments, the record is silent regarding both how the overpayments were made and what method was used to calculate the amount of the overpayments. Representations by a party's counsel do not constitute evidence. See Cruz v. SAIF, 120 Or App 65 (1993). That claimant failed to dispute counsel's representations does not improve the insurer's position,

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[2] We note that, although claimant does not expressly seek a permanent partial disability award on review, he refers to Dr. Thompson's report, which states that, in December 1991, claimant had "some impairment" as a result of his 1990 lumbar strain. (See Ex. 30-6.) We agree with the employer that, inasmuch as Dr. Thompson is not claimant's attending physician, his

In the Matter of the Compensation of
ROBERT S. WIGGET, Claimant
WCB Case No. 92-14689
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nielsen's order that: (1) found that his low back claim was not prematurely closed; (2) awarded temporary disability benefits from October 23, 1991 through May 28, 1992; and (3) declined to award a penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are premature closure, temporary disability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant was medically stationary on May 28, 1992, and therefore, the insurer's closure was proper. However, we note that the dispositive issue is whether claimant was medically stationary at the time of the September 14, 1992 Notice of Closure. After reviewing the record, we agree with the Referee that claimant has failed to establish that his claim was prematurely closed. Based upon the medical examiner's report and the concurrence of claimant's treating physician, we conclude that claimant has failed to prove that, at the time the Notice of Closure issued, further material improvement would reasonably be expected from medical treatment or the passage of time. Consequently, we agree that the claim was not prematurely closed.

Claimant alternatively argues that the insurer's Notice of Closure is void and without legal effect, because the notice was issued 21 days after evidence was received that claimant was medically stationary. Claimant relies on OAR 436-30-020(2), which provides that an insurer's notice of closure shall be issued within 14 days after evidence is received which shows that a worker's condition is medically stationary. Claimant also relies on OAR 436-30-020(5)(c), which provides that notices of closure issued in violation of the rule are void and without legal effect.

We conclude that OAR 436-30-020(5)(c) is not applicable in this case, as section (c) of the rule refers back to OAR 436-30-020(5), rather than to 436-30-020(1) or (2). OAR 436-30-020(5) specifically pertains to situations involving an insurer's "Determination Request," and provides that the insurer shall not issue a notice of closure if an insurer's Form 1503 has been set to the Department within the past 70 days and is still pending resolution. Here, there is no evidence that the insurer's Notice of Closure was issued while a matter involving a determination request was still pending. Accordingly, the rule relied upon by claimant does not apply.

Finally, regardless of the applicability of the Department rules cited by claimant, we have previously held that whether a worker is medically stationary is fundamentally a medical question. Timothy H. Krushwitz, 45 Van Natta 158 (1993). As explained above, claimant has failed to establish that further material improvement would reasonably be expected from medical treatment or the passage of time. Therefore, claimant has not proven that his claim was prematurely closed by the Notice of Closure.

Temporary Disability Benefits

We adopt the Referee's Conclusions of Law and Opinion on this issue.

Penalties

We adopt the Referee's Conclusions of Law and Opinion on this issue.

ORDER

The Referee's order dated April 28, 1993 is affirmed.

In the Matter of the Compensation of
GARRY D. SMITH, Claimant
WCB Case No. 93-01991
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of that portion of Referee McWilliams' order that directed it to pay temporary disability benefits for periods from October 18, 1989 through January 25, 1990 and April 20, 1990 through February 27, 1991. Claimant requests an attorney fee under ORS 656.382(1), based on the employer's failure to pay compensation ordered by a prior stipulated order. On review, the issues are jurisdiction, temporary disability and attorney fees.

We affirm and adopt the Referee's order.

The employer offers no explanation for its failure to pay the temporary disability compensation due under the previously approved stipulated order, beyond its contention that the prior referee lacked authority to order that compensation paid. However, based on the August 27, 1992 Order on Reconsideration and the terms of the parties' January 19, 1993 Settlement Stipulation and Order, the prior referee did have authority to order claimant's (substantive) temporary disability compensation paid.[1] Under these circumstances, the employer has refused to pay compensation due under the prior referee's stipulated order and claimant is entitled to an attorney fee on this basis. 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 fee for claimant's attorney's services on review concerning the refusal to pay compensation due under the prior referee's stipulated order is $750. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value to claimant of the interest involved.

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

ORDER

The Referee's order dated August 4, 1993 is affirmed. Claimant's counsel is awarded an employer-paid attorney fee of $750 for the employer's refusal to pay compensation due under the Referee's order. For services on review concerning the temporary disability issue, claimant's counsel is awarded an attorney fee of $500, payable by the employer.

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[1] The Hearings Division has jurisdiction to enforce a settlement agreement and the parties are bound by the terms of their agreement. See Howard v. Liberty Northwest Ins. Corp., 94 Or App 283 (1988); Evans v. Rookard, Inc., 85 Or App 213 (1987). In addition, we note that the parties signed the January 1993 Stipulation after the August 27, 1992 Order on Reconsideration established claimant's substantive entitlement to temporary disability compensation for the periods in question.

because we are not persuaded that the insurer has presented sufficient evidence of an overpayment in the first instance. Accordingly, we affirm that portion of the Referee's order that declined to authorize an offset.[3]

Although claimant has prevailed against the insurer's cross-request for review of its offset claim, claimant nevertheless is not entitled to an attorney fee under ORS 656.382(2), because an offset would not have reduced or disallowed any portion of claimant's award. See Strazi v. SAIF, 109 Or App 105 (1991).

ORDER

The Referee's order dated June 7, 1993 is affirmed.

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[3] The Referee also concluded that ORS 656.313(2) would affect the employer's claim of overpayment. The employer asserts that ORS 656.313(2) does not apply to either all or part of the alleged overpayments. Inasmuch as we have concluded that the employer's offset claim fails for want of sufficient evidence, we need not address that issue. Nevertheless, we note that, as to that portion of claimant's temporary disability benefits that the employer paid pending review of the earlier referee's order setting aside the denial of claimant's lumbar strain claim, the Referee's reasoning is consistent with prevailing case precedent. See e.g., Debbie L. Stadtfeld, 44 Van Natta 1474 (1992).

March 7, 1994 Cite as 46 Van Natta 357 (1994)

In the Matter of the Compensation of
GWEN A. JACKSON, Claimant
WCB Case No. 93-01851
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Podnar's order which: (1) found that the Hearings Division lacked jurisdiction over claimant's claim for proposed bilateral carpal tunnel surgery; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable conduct in failing to process the claim. On review, the issues are jurisdiction, medical services, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant has a compensable December 5, 1988 neck injury.

Claimant also has a compensable occupational disease for bilateral carpal tunnel and cubital tunnel syndromes.

On August 18, 1992, Dr. Puziss requested authorization for bilateral carpal tunnel releases. The insurer failed to process the claim within 90 days of receipt of the claim.

Claimant requested a hearing on the "de facto" denied surgery request on February 15, 1993.

On March 23, 1993, the insurer requested Director review of the proposed surgery. On May 7, 1993, the Director advised the insurer that the Director was continuing its review of claimant's surgery request. However, at the time of May 11, 1993 hearing before the Referee, the Director had yet to issue an order concerning the proposed surgery.

As of the date of hearing claimant had yet to undergo bilateral carpal tunnel surgery.

ULTIMATE FINDINGS OF FACT

The proposed surgery requested by Dr. Puziss was necessary and appropriate medical services for the compensable bilateral carpal tunnel condition.

The insurer's claim processing of the proposed surgery claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee found that the Director had exclusive jurisdiction over the compensability of claimant's proposed surgery request. Therefore, the Referee concluded that the Hearings Division lacked jurisdiction over this medical services dispute. As a corollary, the Referee also held that the Hearings Division did not have jurisdiction over the related matter of penalties and attorney fees.

Subsequent to the Referee's order, the court has recently concluded that if any party initiates the Director's review of a medical services dispute pursuant to ORS 656.327, then that process is the exclusive means of review. Meyers v. Darigold, Inc., 123 Or App 217 (1993). However, in a subsequent case of Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the court specifically addressed whether ORS 656.327 applied in the context of proposed medical treatment.

In Jefferson, the court concluded that the language of ORS 656.327 was clear, and that the statute expressly applied only to treatment that the claimant "is receiving" at the time the Director is asked to review the dispute. The court held that the process of review by the Director did not apply to requests for future medical treatment, and that the Hearings Division and the Board have jurisdiction to resolve disputes concerning proposed medical treatment. Jefferson v. Sam's Cafe, supra.

Here, the medical services at issue is proposed surgery. Consequently, we conclude that the Director did not have jurisdiction over this matter. See Jefferson v. Sam's Cafe, supra. Therefore, we hold that the Referee had jurisdiction over the compensability of claimant's proposed surgery as well as the related issue of penalties and attorney fees. See ORS 656.262(10).

At hearing no testimony was taken, but exhibits were admitted into evidence. Our review of the record indicates it is sufficient for review. Moreover, we have no reason to believe that the record was not fully developed to the satisfaction of the parties on these issues. We note that neither party on review requests that this case be remanded upon a finding of jurisdiction. Consequently, we conclude remand is unnecessary and we proceed to the merits of the claim.

Medical Services

Claimant asserts entitlement to proposed bilateral carpal tunnel surgery. The insurer contends that the proposed surgery is not reasonable or necessary. ORS 656.245(1)(a) 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..."

In addition, OAR 436-10-040(1)(a) provides:

> "Medical services...provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to professional standards, or to these rules, or which are unrelated to the compensable injury are not reimbursable."

It was the medical opinion of the attending physician, Dr. Puziss, that claimant required bilateral carpal tunnel surgery. This opinion was based on clinical testing and examinations, familiarity with claimant's history, and reliance on Dr. Long's positive nerve conduction studies. (Exs. 43, 82, 88, 95). In contrast, it was the opinion of Dr. Button that surgery was contraindicated. In his view, the "primary working diagnosis" was related to claimant's psychologic profile and not to any organic disease process, including carpal tunnel syndrome. He based this opinion on his review of the medical record, his examination of claimant, and the negative nerve conduction studies performed by Dr. Ellison. (Exs. 84, 89, 91).

In response to Dr. Button's opinions, Dr. Puziss indicated that he was fully aware of claimant's psychological history, but remained convinced that claimant's clinical and electrical findings supported a diagnosis of carpal tunnel syndrome and the need for surgery. Dr. Puziss further contends that Dr. Button relied on an inaccurate history (in that Dr. Button's report does not reflect that he was aware that claimant awoke at night with hand symptoms), and that Dr. Button's testing was inadequate (Dr. Button apparently did not perform pin prick testing or sufficient right hand grip testing).

In weighing the respective medical opinions, we give more weight to the opinion of the attending physician absent a reason to do otherwise. See Weiland v. SAIF, 64 Or App 610 (1982). In this case we find no persuasive reason to disregard the opinion of claimant's attending physician.

Dr. Puziss first saw claimant in October 1989, and has followed her care for three years. (Ex. 88). As such he has had an extended opportunity to examine and evaluate claimant's condition, whereas Dr. Button examined claimant but once. In addition, Dr. Puziss has provided a thorough and well reasoned opinion. For these reasons, we give more weight to the opinion of Dr. Puziss.

Accordingly, based on the medical evidence, we find that claimant has carried her burden of proof establishing that the proposed surgery was necessary and appropriate medical services resulting from the compensable carpal tunnel condition. Thus, the claim is compensable.

Penalties and Attorney Fees

Claimant also asserts that the insurer's failure to process the claim for the proposed surgery was unreasonable claim processing for which the insurer should be assessed penalties and/or attorney fees. We consider the insurer's conduct to have been unreasonable. However, since there are no unpaid bills for such services in the record, there are no "amounts then due" on which to assess a penalty. Although a penalty is not appropriate under these circumstances, we award an attorney fee for the insurer's unreasonable resistance to claimant's attending physician's clear request for compensation. We base our conclusions on the following reasoning.

If the insurer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer shall be liable for an additional amount up to 25 percent of the amounts then due. ORS 656.262(10). ORS 656.382(1) allows for an assessed attorney fee for an unreasonable resistance to the payment of compensation provided there are no amounts then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10). See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

On August 18, 1992, claimant's attending physician requested the insurer to authorize surgery for claimant's compensable carpal tunnel condition. (Ex. 82). The record indicates the insurer received this request on August 26, 1992. (Ex. 83). Based on this evidence, we find that the insurer was provided notice of a claim for medical services on August 26, 1992. See ORS 656.005(6); 656.245(1).

Written notice of acceptance or denial of a claim shall be furnished to claimant by the insurer within 90 days after the insurer has notice or knowledge of the claim. ORS 656.262(6). Thus, the insurer was required to accept or deny the claim within 90 days of receipt of the claim. In this case, the insurer neither accepted nor denied the claim within the statutory period. Therefore, we find the claim was "de facto" denied and the insurer's claim processing was unreasonable. See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992); Barr v. EBI Companies, 88 Or App 132 (1987).

We recognize that at the time the insurer was required to process the claim, there were Board decisions which indicated that the Director had jurisdiction over these types of medical services disputes and that it was improper to issue a claim denial. See Debra Layng, 44 Van Natta 815 (1992). Still, the insurer did not file notice that it was seeking Director's review under ORS 656.327(1) until March 23, 1993, after claimant had filed a request for hearing. (Ex. 96). This was well past the statutory period for timely processing of the claim. Considering these circumstances, we continue to find that the insurer's claim processing in this case was unreasonable. See ORS 656.382(1); compare Robert P. Holloway, 45 Van Natta 2036 (1993), on recon 46 Van Natta 117 (1994).

This order has found that claimant's proposed surgery constitutes compensable medical services. Therefore, we find that the insurer has unreasonably resisted the payment of compensation. The issue now becomes whether there are any "amounts then due" upon which to base a penalty under ORS 656.262(10). There is no evidence of unpaid medical bills in the record. Accordingly, there are no "amounts then due" upon which to base a penalty.

Where there has been an unreasonable resistance to the payment of compensation, but there are no amounts then due upon which to base a penalty and the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10), claimant is entitled to an assessed attorney fee under ORS 656.382(1). See Martinez v. Dallas Nursing Home, supra.

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 the unreasonable conduct 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 the record), the complexity of the issue, and the value of the interest involved.

Claimant is not entitled to an assessed attorney fee under ORS 656.386(1). SAIF v. Allen, 124 Or App 183 (1993). In Allen, the claimant had sustained a compensable injury. SAIF, as the responsible insurer, paid some medical bills, but not all. The claimant requested hearing on the unpaid bills. Just prior to hearing, SAIF paid the bills and the parties agreed that the claimant was entitled to penalties and attorney fees. ORS 656.262(10); 656.382(1). Thus, the sole issue at hearing was attorney fees under ORS 656.386(1). The Board, affirming the Referee, held that the claimant's counsel was instrumental in obtaining compensation for the claimant without a hearing, and on that basis awarded fees pursuant to ORS 656.386(1). The court reversed.

Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." The court noted that the compensability of the claimant's injury was not disputed. Rather, claimant sought a hearing regarding nonpayment of some medical bills. Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute." Because the hearing in Allen pertained to nonpayment of medical bills and because compensability was never disputed, the claimant's attorney was not entitled to an award of fees under ORS 656.386(1).

In the present case, the dispute pertains to medical services for an accepted claim. The record indicates there was no dispute concerning whether or not the proposed surgery was causally related to claimant's compensable carpal tunnel condition. That point was conceded by the insurer. Rather, the issue at hearing was whether or not the proposed surgery constituted reasonable and appropriate medical services. (Ex. 94; Tr. 8, 11-12). Based on the court holding in Allen, an attorney fee may not be awarded under ORS 656.386(1) since the subject of the hearing was not a dispute about the "compensability" of the claim. See SAIF v. Allen, supra; see also Robert P. Holloway, Sr., supra.

ORDER

The Referee's order dated May 26, 1993 is reversed. The insurer's "de facto" denial is set aside and the claim remanded to the insurer for processing in accordance with law. Claimant's counsel is awarded an assessed attorney fee of $2,500 for the insurer's unreasonable resistance to the payment of compensation pursuant to ORS 656.382(1), payable by the insurer.

In the Matter of the Compensation of
THOMAS E. JOHNSTON, Claimant
WCB Case Nos. 92-06869, 92-06868, 91-15014, 92-03321 & 92-09254
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of those portions of Referee Myzak's order that: (1) set aside its denial, on behalf of Mt. Mazama Plywood, of claimant's neck condition; and (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of Emerald Forest Products, of the same condition. Liberty cross-requests review of that portion of the order finding it responsible for claimant's psychological condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

On April 19, 1983, claimant compensably injured his right arm while working as a core feeder for SAIF's insured, Mt. Mazama Plywood. (Ex. 1). After undergoing bilateral carpal tunnel releases, claimant returned to work as a glue spreader. (Ex. 8-1). In September 1983, claimant complained of "discomfort in the shoulder & neck from the overhead work." (Id.) Claimant continued to receive treatment for his right shoulder and neck. (Exs. 8-2, 8-3, 9). In December 1983, claimant reported that, in May 1983, "he had some posterior neck pain but received physical therapy for this and after 4-5 weeks, this resolved." (Ex. 10). Throughout 1984, 1985, and 1986, claimant underwent multiple surgeries on his wrists and elbows. (Exs. 12, 13, 15, 18, 25).

In 1986, claimant worked as a core feeder for Liberty's insured, Emerald Forest Products. (Ex. 26). After claimant filed a claim for arm pain, responsibility for the previously accepted bilateral shoulder condition shifted from Mt. Mazama to Emerald Forest Products. (Ex. 50). After filing the claim, claimant continued seeking treatment for his shoulders, undergoing additional surgeries. (Exs. 37, 40). In August and December 1987, claimant denied having any neck symptoms. (Exs. 35-1, 38-2).

After another surgery on claimant's left wrist by Dr. Teal, in June 1988, claimant was declared medically stationary with regard to his bilateral shoulder and arm condition and released to modified work. (Exs. 42, 44). Claimant has not worked since December 1986.

In July 1988, claimant sought treatment for left neck and shoulder pain. (Exs. 46, 47). In May and June 1989, claimant again sought treatment in Nevada for persistent neck and right shoulder pain. (Exs. 51, 53, 54). Apparently, claimant shortly thereafter returned to treatment with Dr. Teal, who referred claimant to Dr. Karasek, neurologist, and Dr. Kitchell, orthopedic surgeon. (Exs. 55, 56). After Dr. Teal performed another right carpal tunnel release in November 1989, Dr. Karasek became claimant's treating physician for his neck condition. (Exs. 59, 60, 63). In March 1991, a cervical CT scan revealed a disc herniation causing compression on the right C6 nerve root. (Ex. 73).

In May 1991, claimant sought treatment for depression.

SAIF, on behalf of Mt. Mazama Plywood, denied claimant's neck and psychological conditions. [illegible] Forest Products, also denied both conditions.

There are numerous opinions regarding the cause of claimant's neck symptoms. Dr. Karasek, claimant's treating neurologist, reported to claimant's attorney that claimant had a "cervical disc syndrome which is more probably than not related to his work activities as a core feeder on a spreader crew," noting that the "cervical disc and arm pain syndrome occurred at approximately the same time" and consisted of similar symptoms. (Ex. 96). Dr. Karasek further stated that claimant's "A/C joint arthritis" would not cause the cervical disc condition. (Id.) Dr. Karasek subsequently agreed, however, with a letter written by SAIF's attorney stating that claimant's "current cervical condition is causally related to his 1986 occupational disease [Liberty Northwest] claim." (Ex. 102A).

Dr. Hacker evaluated claimant upon referral from Dr. Karasek. Dr. Hacker stated that claimant's "cervical spine difficulties commenced with his injury in 1983 as described to me by [claimant]. Having listened to [claimant's] history, I expect that multiple injuries account for his present condition. I do not have a strong opinion regarding whether the injury in 1986 is the major cause of his cervical diagnosis." (Ex. 87).

Dr. Hacker later reported that, based on claimant's history, "[n]eck problems have been present ever since [the 1983 injury] with symptoms radiating about the scapula and both arms. I expect that this is the major source of [claimant's] ongoing neck difficulties." (Ex. 95). Dr. Hacker reiterated this opinion during his deposition, emphasizing that it was based on a history that neck symptoms initiated with the 1983 injury and did not thereafter resolve. (Ex. 109-11, 109-21). Dr. Hacker also stated that he saw claimant only one time and had not reviewed any records before August 1987 when he rendered his opinion. (Id. at 11, 22-23).

Dr. McKillop, orthopedic surgeon, conducted a medical evaluation for Liberty. He found that, because claimant's radiculopathy from his neck had begun with "his most recent injury in December, 1986, [] I would be of the opinion that his neck symptoms probably do relate to work activity in 1986. While he had neck symptoms prior to that time, there is nothing in the records to indicate that he had a radiculopathy." (Ex. 88-6).

Dr. Hockey, neurosurgeon, conducted a second medical examination for Liberty, stating that the "major contributing cause of [claimant's] symptoms and need for surgeries was the industrial injury of 1983. It is well documented in talking to [claimant] and reviewing his charts that all of his complaints started in 1983." (Ex. 101-4).

During a deposition, Dr. Hockey stated that he understood that claimant sustained no direct injury to his neck in 1983. (Ex. 108A-7). He also clarified his earlier report that he had not included neck symptoms when he stated that the 1983 injury was the major contributing cause of claimant's "symptoms and need for surgeries." (Id. at 9). Dr. Hockey further stated that he could not prove that claimant's neck symptoms were related to his work activities. (Id. at 9, 20). Therefore, we find that Dr. Hockey did not provide an opinion regarding the cause of claimant's cervical condition.

Finally, Drs. Brooks, neurologist, and Coletti, orthopedist, performed a medical examination for SAIF. Their report stated that, based on the medical records and claimant's statements, "there is no good evidence to suggest that his cervical disc condition is related to his injury of April 19, 1983 or even to his work at Mt. Mazama Plywood. The medical record does not suggest a history of neck problems until he began seeing a doctor in 1989 with complaints of neck pain." (Ex. 108-7). The report further found that claimant's "disc herniation reflects the results of degenerative disc disease and we would not relate it to any specific incident or work activity." (Id.).

After reviewing the record and claimant's testimony, we first note that claimant is not a reliable historian with regard to his neck condition. Claimant testified that he sustained an injury to, and sought treatment for, his right shoulder and neck while working at Mt. Mazama Plywood in April 1983. (Tr. 12-13). He further stated that his neck pain decreased for some time in 1983 but thereafter became

Therefore, although we do not necessarily disagree with the Referee that claimant is credible, we find that he is not an accurate historian. Consequently, we do not rely on claimant's testimony regarding the history of his neck symptoms. Moreover, in view of claimant's prior compensable shoulder condition, multiple work exposures, and degenerative condition, we find that the issue of causation is a complex medical question. Thus, resolution of the issue 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).

Based on the foregoing discussion, we disagree with the Referee's conclusion that Dr. Hacker provided the most persuasive opinion. Dr. Hacker based his opinion solely on claimant's history that claimant injured his neck in April 1983 and that neck symptoms persisted after that date. The medical record does not support such a history. Although there is evidence that claimant experienced some neck symptoms in 1983, the medical record indicates that such symptoms resolved shortly thereafter. Furthermore, the record shows that claimant did not complain about neck symptoms again until July 1988. Therefore, having found that Dr. Hacker's opinion is based on an inaccurate history, we give it little weight. See Somers v. SAIF, 86 Or App 259 (1986).

We also find that Dr. McKillop's opinion is not persuasive. Like Dr. Hacker, it appears that Dr. McKillop based his opinion on claimant's reporting of his history rather than the medical record. (See Ex. 76). Because Dr. McKillop indicated that claimant's neck symptoms began in 1986, and such a history is not supported by the medical record, we also find that Dr. McKillop's opinion is based on an inaccurate history.

Furthermore, Dr. McKillop's opinion regarding causation is not consistent. Dr. McKillop first indicated that work activities, and not claimant's prior compensable 1986 shoulder condition, caused his cervical condition. However, he later concurred with a letter stating that the cervical condition was "causally related" to the 1986 shoulder condition.

Thus, having found that Dr. McKillop's opinion is based on an inaccurate history and not well-reasoned, we also give it little weight. See Somers v. SAIF, supra.

We do find, however, that the opinion of Drs. Brooks and Coletti is based on an accurate history insofar as it indicated that the onset of claimant's neck symptoms was after he stopped working at Mt. Mazama Plywood and Emerald Forest Products. According to their thorough and well-reasoned opinion, claimant's cervical condition is not related to any work injury or work activity.

Consequently, in view of the persuasiveness of the opinion of Drs. Brooks and Coletti, and the unreliability of the remaining opinions, we conclude that claimant failed to prove compensability. See ORS 656.802(2); 656.005(7)(a)(B).

Compensability of Psychological Condition

Claimant asserts that his psychological condition is a compensable consequence of his industrial injuries. Because claimant contends that his psychological condition is related to a compensable injury rather than independently work connected, we agree with the Referee's application of ORS 656.005(7)(a)(A) rather than ORS 656.802 to analyze compensability. See SAIF v. Hukari, 113 Or App 475, 480 (1992).

Furthermore, we agree with the Referee that Dr. Henderson, as the treating psychiatrist, provided the most reliable opinion. See Weiland v. SAIF, supra. In his most recent report, which clarified previous opinions, Dr. Henderson explained that claimant's compensable bilateral shoulder condition was the major cause of his pain and decreased ability to function and, therefore, of his resultant dysthymic disorder. (Ex. 110-1). That opinion essentially is not contested. Dr. Holland, psychiatrist, also diagnosed dysthymia and, with regard to causation, stated only that the 1983 injury was not the major contributing cause of his need for treatment. (Ex. 82-24). Dr. Davies, psychologist who evaluated claimant for rehabiliation services, and Dr. Quan, psychiatrist, offered no opinions regarding causation. (Exs. 79, 89).

Consequently, we conclude that claimant proved that his compensable bilateral shoulder condition is the major contributing cause of his psychological condition and, therefore, his claim is compensable. See ORS 656.005(7)(a)(A). Inasmuch as Liberty is responsible for the bilateral shoulder condition, it also is responsible for claimant's psychological condition.

Claimant's counsel is entitled to an assessed attorney fee for services on review for prevailing against Liberty's cross-request for review. After considering the factors set forth in OAR 438-15-010(4) and applying them to the psychological condition issue, we find that a reasonable fee for services on review concerning Liberty's cross-request is $1,000, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated January 12, 1993 is reversed in part and affirmed in part. SAIF's denial of claimant's cervical condition is reinstated and upheld. The Referee's award of an assessed attorney fee of $3,500 is reversed. The remainder of the order is affirmed. For services on review regarding Liberty's cross-request for review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Liberty.

March 7, 1994 Cite as 46 Van Natta 364 (1994)

In the Matter of the Compensation of
FRANK H. KNOTT, Claimant
WCB Case No. 92-08626
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Crumme's order that: (1) reversed an Order on Reconsideration award of 16 percent (51.2 degrees) unscheduled permanent disability for claimant's low back injury; and (2) declined to award an attorney fee award under ORS 656.382(2) regarding the insurer's successful appeal of the reconsideration order. If claimant is awarded permanent disability, the insurer requests authorization to offset overpaid temporary disability. On review, the issues are extent of unscheduled permanent disability, attorney fees, and offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for findings numbered 9 and 10 and the "Discussion of Findings," with the following supplementation.

Claimant has suffered a permanently reduced range of motion in the thoracic and lumbar areas of his back which are the result of his January 6, 1990 compensable injury.

CONCLUSIONS OF LAW AND OPINION

The parties agree that claimant's reduced thoracic and lumbar range of motion would be valued at 16 percent under the "standards" if this impairment is injury-related. Thus, the question is whether claimant's impairment results from his compensable 1990 strain injury. See ORS 656.214(5); OAR 436-35-007(1).

The Referee found that claimant's reduced ranges of motion are due to an underlying noncompensable degenerative condition rather than the compensable injury. We disagree.

Claimant's back problems began with his 1990 strain injury at work. His symptoms have waxed and waned since his strain, but they have never completely resolved. (See Ex. 28A). There is no suggestion that claimant's symptoms and decreased ranges of motion are less than genuine. He has been consistently diagnosed as suffering from a "low back strain," which eventually became chronic. (Exs. 10, 19, 21, 24).

The medical evidence regarding the etiology of claimant's back impairment is provided by Drs. Berselli, Dineen and Rosenbaum.

On June 3, 1992, Dr. Dineen, medical arbiter, examined claimant and reported his "Impression: (1) Status post thoracolumbar strain." (Ex. 33A). However, subsequent to the Order on Reconsideration, on September 9, 1992, Dr. Dineen signed a letter indicating that claimant's decreased range of motion is more likely related to degenerative disease than to the accepted strain.[1] (Ex. 39). Nonetheless, because Dr. Dineen did not explain this inconsistency, his conclusions are not persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or 630 (1987).

Dr. Berselli, who treated claimant from January 1991 through July 1992, initially suspected that claimant's ongoing back problems were caused by a herniated disc. (Exs. 20, 21). However, after an MRI indicated no nerve root involvement, Dr. Berselli opined that claimant's back problems were solely related to his January 1990 injury. (Exs. 22, 24). In May 1992, Dr. Berselli again suspected that claimant's disc might have extruded further. (Exs. 27, 34). However, x-rays indicated the same moderate bulging disc and degeneration noted on the previous MRI and Dr. Berselli's suspicion was not confirmed. (See Exs. 22 and 36).

The Order on Reconsideration issued on June 16, 1992. Thereafter, Dr. Berselli signed a letter indicating that he could not be certain whether claimant's spinal degeneration or his injury caused the disc condition and could not say whether the degeneration or the strain caused claimant's reduced range of motion.[2] (Ex. 40). Nonetheless, considering Dr. Berselli's admitted uncertainty and his unconfirmed suspicions, the latter conclusory opinion is not persuasive.

Dr. Rosenbaum reviewed claimant's medical record and conducted an examination for the insurer on September 8, 1992. Based on the 1991 and 1992 MRIs, Dr. Rosenbaum described claimant's degenerative changes and two slightly bulging discs (at L4-5 and L5-S1), but concluded that the diagnostic studies were "essentially normal." (Ex. 39A & B).

We consider Dr. Rosenbaum's reports to be both thorough, well-reasoned, and based on complete information. Consequently, we find his opinion to be persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

In our view, Dr. Rosenbaum's persuasive reasoning establishes that neither claimant's degenerative changes nor his bulging discs contribute to his back problems. Dr. Rosenbaum's opinion is also consistent with the radiologists' interpretations of the 1991 and 1992 MRIs. Considering the absence of back problems prior to claimant's compensable injury and the ongoing nature of such problems since the injury, we conclude that claimant has established that his permanent impairment is due to his compensable injury.

In reaching this conclusion, we distinguish this case from the court's recent holding in Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). In Koitzsch, the court reversed a Board order which had used impairment findings from a carrier-referred examining physician "for purposes of supporting or impeaching the opinion and ratings offered by [claimant's physician]."

Relying on ORS 656.245(3)(b)(B), the claimant in Koitzsch argued that the Board had erred in using the examiner's findings because the physician was not the claimant's attending physician. After reviewing the legislative history, the court agreed. Noting that the statute did not make a distinction between offering an examiner's impairment findings for impeachment or proof purposes, the court

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[1] We assume, without deciding, that Dr. Dineen's "post-reconsideration" supplemental report can be considered for both "impairment" and "causation" purposes. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993) (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself). In any event, for the reasons expressed in a later portion of this order regarding our consideration of Dr. Rosenbaum's opinion, we conclude that we are not prohibited from reviewing Dr. Dineen's opinion to the extent that it pertains to the "causation" issue.

[2] As with Dr. Dineen's "post-reconsideration" report, we assume that Dr. Berselli's "post-reconsideration / medical arbiter report" opinion, (Ex. 40), may be considered for both "impairment" and "causation" purposes. See Pacheco-Gonzalez v. SAIF, supra. In any event, again as with Dr. Dineen's report, for the reasons expressed in a later portion of this order regarding our consideration of Dr. Rosenbaum's opinion, we conclude that we are not prohibited from reviewing Dr. Berselli's opinion to the extent that it pertains to the "causation" issue.

reasoned that, even for impeachment purposes, such findings concerned the worker's impairment that evaluate disability. Inasmuch as the Board's consideration of the examiner's findings defeated the statute's objective to permit only attending physicians to make impairment findings, the court held that the Board had erred as a matter of law.

Here, in addition to the opinions authored by the medical arbiter and claimant's attending physician, we have considered the "post-reconsideration" opinion from Dr. Rosenbaum, an examining physician. Nevertheless, as discussed above, our consideration of this opinion has been limited to the issue of whether claimant's permanent impairment is attributable to his compensable injury or to his noncompensable degenerative condition; i.e., whether the impairment is "compensable." Consistent with ORS 656.245(3)(b)(B) and the Koitzsch holding, Dr. Rosenbaum's opinion cannot be received and considered as impairment findings for purposes of evaluating claimant's disability. Those permanent impairment determinations are strictly within the province of claimant's attending physician and the medical arbiter subject to the "no subsequent medical evidence" limitation set forth in ORS 656.268(7). See Pacheco-Gonzalez v. SAIF, supra.

In this regard, we note that our conclusion is supported by the relevant statutory language. ORS 656.245(3)(b)(B) states that "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." (Emphasis supplied). In conjunction with this provision, ORS 656.214(5) provides that the "criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis supplied). Thus, while ORS 656.245(3)(b)(B) limits evidence concerning permanent impairment, it does not limit other evidence, such as evidence concerning the causal relationship between the compensable injury and the permanent impairment, that is necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5).

Finally, as stipulated by the parties, in the event that claimant's permanent impairment is found to be attributable to his compensable injury, such impairment findings support an impairment value of 16 percent under the Director's disability standards. Having now resolved this permanent impairment issue, we proceed to evaluate claimant's permanent disability under the remaining applicable portions of the standards.

Extent of unscheduled permanent disability

Claimant became medically stationary after July 1, 1990, and he made a request for reconsideration pursuant to ORS 656.268. Therefore, in rating his permanent disability, we apply the disability rating standards in effect on the date of the October 25, 1991 Determination Order. OAR 438-10-010, 436-35-003(2). Thus, the applicable "standards," as amended by the temporary rules, are provided in WCD Admin. Orders 2-1991 and 7-1991.

At the outset, we note that the Order on Reconsideration did not assign values for age, education and adaptability factors under the standards, based on a finding that claimant was released to return to his regular work. Since the Referee did not find claimant's impairment related to the compensable injury, the Referee did not address whether claimant returned to his regular work. However, because we are not persuaded that claimant returned to his regular work as of the Order on Reconsideration (see Tr. 12, 33), the standards provide an adaptability value for claimant, as explained below.

Claimant's job at injury as a dock worker had "heavy" strength requirements. (DOT #929.687-030). There is insufficient evidence to establish that claimant has performed any job with greater than heavy strength demands during the 10 years preceding the time of determination. See OAR 436-35-310(1). At the time of reconsideration, claimant was working in the "medium plus" category. (See Ex. 33A). Consequently, we assign a value of 2 for the adaptability factor. See OAR 436-35-310(3).

Claimant's age of 42 years is assigned a value of 1. See OAR 436-35-290(2). He has 3 1/2 years of college education and therefore is not entitled to a value for formal education. He has attained an SVP level of 3 as a dock worker (DOT #929.687-030) for a value of 3. There is no indication in the record that he has attained a higher SVP level. Therefore, claimant is assigned a value of 3 for the education factor. See OAR 436-35-300(3)(e). In addition, claimant is entitled to a value of 1 for training. OAR 436-35-300(5). The sum of the age, education, and training factors equals 5.

Pursuant to the parties' agreement, claimant is entitled to a 16 percent rating for back impairment.

Assembling the factors, we multiply the age, education, training factors total (5) and the adaptability value (2) for a product of 10. That product is then added to the impairment value of 16 for a total of 26 percent. See OAR 436-35-280. Claimant is entitled to 26 percent unscheduled permanent disability for the compensable injury.

The insurer requested a hearing contesting the Order on Reconsideration award of 16 percent unscheduled permanent disability. In the event that his award was not reduced, claimant sought an insurer-paid attorney fee award under ORS 656.382(2). Since the Referee eliminated the Order on Reconsideration award, claimant was not granted the requested attorney fee. However, as a result of our reinstatement and increase of the Order on Reconsideration award, claimant is now entitled to an insurer-paid attorney fee under ORS 656.382(2) for his counsel's services at hearing regarding the permanent disability issue.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing concerning the permanent disability issue is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Claimant's attorney is also entitled to an attorney fee award payable from the increased compensation created by this order. See OAR 438-15-055. As a result of our decision, claimant's unscheduled permanent disability award has been increased from zero (the Referee's award) to 26 percent. The fact that the insurer would be entitled to offset that 26 percent award by all or any portion of the 16 percent unscheduled permanent disability award granted by the Order on Reconsideration, does not detract from the fact that our order increased claimant's substantive entitlement to permanent disability from zero to 26 percent. See Judy A. Jacobson, 44 Van Natta 2393, on recon 44 Van Natta 2450 (1992). Consequently, claimant's attorney is awarded 25 percent of this 26 percent unscheduled permanent disability award, not to exceed $3,800.

Finally, we grant the insurer's request for authorization to offset $525.50, the amount of previously overpaid temporary disability compensation. (See Exs. 30, 31). This offset authorization shall have no effect on claimant's counsel's "out-of-compensation" attorney fee. See OAR 438-15-085(2).

ORDER

The Referee's order dated March 22, 1993 is reversed. The Order on Reconsideration is reinstated and modified. In addition to the Order on Reconsideration award of 16 percent (51.2 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, giving him a total of 26 percent (83.2 degrees) unscheduled permanent disability for a back injury. The insurer is authorized to offset $525.50 in overpaid temporary disability compensation from this award. Claimant's attorney is awarded an out-of-compensation attorney fee in the amount of 25 percent of the 26 percent (83.2 degrees) increased unscheduled permanent disability compensation created by this order, not to exceed $3,800. This attorney fee award shall not be subject to the authorized offset. For services at hearing regarding the insurer's request for hearing, claimant's attorney is awarded $1,500, to be paid by the insurer.

Board Members Haynes and Neidig dissenting.

The majority concludes that claimant has proven injury-related permanent disability, based on the opinion of Dr. Rosenbaum, who examined claimant once at the insurer's request. In reaching this conclusion, the majority apparently reads Rosenbaum's statement that diagnostic MRIs are "essentially normal" as evidence supporting its reasoning that claimant's continuing problems must be injury-related because there is no other explanation. The majority's reasoning is not only illogical, it is contrary to law. Claimant simply cannot carry his burden concerning causation by merely disproving nonwork-related explanations for his impairment. See ORS 656.266. Just because claimant suffered a compensable back strain in 1990, it does not necessarily follow that his back problems are injury-related years later.

Claimant is only entitled to permanent disability compensation for injury-related impairment. ORS 656.214(5); OAR 436-35-007(1). In this case, there is no persuasive medical evidence relating claimant's impairment (reduced back ranges of motion) to the 1990 work injury. The medical arbiter expressed no opinion regarding the etiology of claimant's reduced ranges of motion. (Unlike the majority, we find nothing inconsistent about his opinion). Claimant's treating physician is unable to explain claimant's continuing back problems. Dr. Rosenbaum believes that claimant's back is normal. We fail to see how any of these "opinions" support an award for injury-related permanent disability. Nonetheless, despite the complete lack of empirical or medical evidence addressing causation, the majority apparently infers that the necessary causal relationship is present, from the onset and continuation of claimant's symptoms. In this medically complex case, we believe that a mere lay inference is insufficient to carry claimant's burden. Accordingly, we respectfully dissent.

March 7, 1994 Cite as 46 Van Natta 368 (1994)

In the Matter of the Compensation of
DONALD L. LEWIS, Claimant
WCB Case No. C4-00289
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Member Gunn and Haynes.

On January 31, 1994, 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 approve the proposed disposition.

The proposed CDA has provided for the release of "all benefits," with the exception of medical services. CDA, Pg. 1, Pg. 3, paragraph 12. The CDA does not expressly refer to attorney fees. However, the proposed CDA was submitted with a letter from claimant which stated that claimant understood that the CDA was not intended to adversely affect claimant's rights to medical services and to a possible attorney fee if the self-insured employer denied future medical services. The letter further stated that approval of the CDA was requested, if the Board construed the language consistent with the parties' "understanding." Finally, the letter stated that if the Board construed the language differently (i.e., to preclude the possibility of a future attorney fee for medical services disputes), then "claimant would ask the Board to disapprove the CDA as unreasonable as a matter of law."

On February 14, 1994, because claimant's letter could have been construed as representing dissatisfaction with the executed CDA, we requested clarification of the parties' positions. Within 10 days we received a timely response from claimant. Inasmuch as the 10-day period has expired, we proceed with our review.

Seeking approval of the CDA, claimant asserts that the CDA "can and should be interpreted to be consistent with the provisions and limitations of ORS 656.236."

We agree that the CDA complies with the statute and we find that the agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. Accordingly, we do not find any statutory basis for disapproving the agreement. Therefore, this claim disposition agreement is approved.

In approving this CDA, we make no decision regarding a future, possible attorney fee issue. First, we find no provision within the CDA pertaining to preclusion of a possible future attorney fee for services on medical disputes. However, even if the parties had drafted a CDA containing such a provision, we would decline to address such an "issue."

First, the Board's statutory review of a CDA is limited to whether the proposed agreement disposes of releasable matters concerning an accepted claim, in accordance with the terms and conditions prescribed by the Director. ORS 656.236(1). Second, as we have previously held, the function of a CDA is to dispose of accepted claims, with the exception of medical services, as those claims exist at the time the Board receives the CDA. Debra L. Smith-Finucane, 43 Van Natta 2634 (1991).

It is conceivable that a future attorney fee or other subsequent claim processing issue may well be the subject of a future dispute. Since such a dispute would raise a question concerning a claim, the dispute could be presented to a referee for resolution. ORS 656.283(1). Nevertheless, no such dispute exists at this time. Moreover, even if a dispute existed, it would not be appropriate for the Board to resolve it under its ORS 656.236 authority.

Finally, we note that the CDA does not attempt to incorporate by reference the parties' discussions or any "side" agreements pertaining to a possible future attorney fee issue. Nor have the parties attempted to formally amend the original CDA through our addendum process. OAR 438-09-020(2). Under such circumstances, we review only the executed CDA as drafted by the parties. As explained above, the CDA is not unreasonable as a matter of law and is in compliance with the statute and the rules. We, therefore, approve the parties' agreement.

IT IS SO ORDERED.

March 7, 1994 Cite as 46 Van Natta 369 (1994)

In the Matter of the Compensation of
MARY L. MILLER, Claimant
WCB Case No. 93-01466
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Spangler's order that found that claimant's occupational disease claim for bilateral carpal tunnel syndrome is barred by res judicata. On review, the issues are res judicata and compensability. We modify.

FINDINGS OF FACT

Claimant, a 40-year-old medical technologist with no preexisting hand or wrist problems, began working for the employer in May 1988. Her job duties required the repetitive use of her fingers, hands and wrists.

Specifically, claimant worked two to three days a week, eight hours a day. In the summer, she worked more than two to three days a week. Eighty percent of her day was spent operating a differential counter (i.e., a keypad) with her left hand. While doing that, she focused a microscope by turning a round knob with her right hand, She gripped the knob between her index finger and thumb. To turn the knob forwards and backwards, she rotated her wrist and hand.

In addition, claimant used her left hand to operate a smaller hand-held counter. Again, while doing so, she focused a microscope with her right hand. She also used her right hand for handwriting.

Beginning in late 1990 or early 1991, claimant began experiencing problems with her hands and wrists. She felt numbness and tingling in the morning after doing the "differentials" for a few hours. After shaking her hands, she would continue working. At night, her symptoms caused her to awaken.

In May 1991, claimant was examined by Dr. Snider, an orthopedic surgeon. The examination revealed pain, hypesthesia, and a positive Phalen's and median compression test. Dr. Snider diagnosed possible carpal tunnel syndrome and treated with aspirin, vitamin B-6 and wrist splints. A few weeks later, claimant was examined by neurologist Dr. Shwarz.

In late May 1991, claimant filed a claim for a bilateral carpal tunnel condition, with symptoms of numbness, tingling, weakness and pain. (Ex. D1A).

In July 1991, claimant was examined by hand surgeon, Dr. Nye, at the insurer's request. On August 13, 1991, the insurer issued a letter denying the claim for carpal tunnel syndrome. (Ex. I1). Claimant did not appeal the denial.

Claimant continued to work as a medical technologist. On October 26, 1992, after more than a year without treatment, claimant returned to Dr. Snider with increased carpal tunnel symptoms. Dr. Snider treated with hand therapy and wrist splints.

On October 30, 1992, claimant filed a claim for a bilateral hand, wrist and arm condition, with symptoms of numbness, tingling and pain. On the 801 claim form, claimant indicated that her symptoms were the "same" as before, though "stronger." (Ex. 3).

In January 1993, claimant was examined by hand surgeon Dr. Button at the insurer's request. On January 27, 1993, the insurer issued a letter denying the claim. Claimant timely appealed the denial. Claimant was subsequently examined by Dr. Radecki at the insurer's request.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that res judicata bars claimant from asserting her current claim for bilateral carpal tunnel syndrome (CTS). Citing Wasson v. Evanite Fiber Corp., 117 Or App 246 (1992), the Referee reasoned that, inasmuch as claimant had failed to appeal the insurer's August 13, 1991 denial of claimant's previous claim for CTS, she is barred from raising the current claim for even a worsening of her CTS.

On review, the insurer concedes that the Referee erred in applying Wasson to the facts of this case. The insurer contends, however, that claimant has not established a worsened condition so as to avoid the preclusive effect of its prior denial. Alternatively, if we determine that claimant has established a worsening so as to avoid claim preclusion, the insurer contends that there is no evidence of a pathological worsening of the CTS and that claimant has, therefore, failed to prove the compensability of her current claim. 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, mod 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).

Because claimant did not appeal the August 13, 1991 denial, her bilateral CTS condition was not compensable as of the date of that denial. Her current CTS claim, therefore, is properly characterized as a claim for a worsening of a preexisting noncompensable condition. See Brian M. Lundquist, 45 Van Natta 358, 360 (1993); Duane A. Alioth, 44 Van Natta 216 (1992); Anna M. Turner, 41 Van Natta 1956 (1989).

A preponderance of the evidence in the record establishes that claimant's carpal tunnel symptoms worsened after the August 13, 1991 denial. Claimant credibly testified that her symptoms grew worse after August 13, 1991. (Tr. 15). Her testimony is supported by Dr. Snider's October 26, 1992 chart note, which reports "increasing discomfort and inability to hold objects in a flexed manner at the wrist." (Ex. 1). Claimant's testimony is also supported by the fact that she had not sought treatment for more than a year prior to returning to Dr. Snider. In addition, on her October 1992 801 claim form, claimant noted "stronger symptoms last 4-6 months." (Ex. 3).

Because we find that claimant's carpal tunnel symptoms worsened since the August 13, 1991 denial, we conclude that the denial does not preclude claimant from asserting the current CTS claim. See Gabriele H. Flores-Linsner, 45 Van Natta 307 (1993) (citing Kepford v. Weyerhaeuser, 77 Or App 363, rev den 300 Or 722 (1986)). Nevertheless, claimant must still establish the compensability of her CTS claim.

Claimant's carpal tunnel condition arose gradually and was not an unexpected hazard of exposure to work conditions involving repetitive use of hands and wrists. Therefore, we find that claimant's CTS claim is best analyzed as an occupational disease, rather than an injury. See James v. SAIF, 290 Or 343 (1980); O'Neal v. Sisters of Providence, 22 Or App 9 (1975).

In order to establish an occupational disease claim for bilateral CTS, claimant must prove by a preponderance of the evidence that her work activities were the major contributing cause of a pathological worsening of the preexisting CTS condition since the August 13, 1991 denial. See ORS 656.802(2); Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Brian M. Lundquist, supra. Claimant has not sustained her burden of proof.

Dr. Snider, the attending physician, reported increased carpal tunnel symptoms when claimant saw him on October 26, 1992. However, his report does not indicate that claimant's underlying CTS has pathologically worsened. (Ex. 1). Dr. Snider's subsequent reports also do not mention a pathological worsening. (Exs. 5, 6A). Drs. Button and Radecki also do not mention a pathological worsening of the underlying CTS. (Exs. 4, 7). In fact, Dr. Radecki reported that electrodiagnostic studies were "normal," indicating no slowing of the median nerves. (Ex. 7-5).

Absent persuasive evidence of a pathological worsening, we conclude that claimant's CTS claim is not compensable. Accordingly, the insurer's January 27, 1993 denial is upheld on the merits.

ORDER

The Referee's order dated May 10, 1993 is modified. The insurer's January 27, 1993 denial is upheld.

March 7, 1994 Cite as 46 Van Natta 371 (1994)

In the Matter of the Compensation of
WILLIAM J. SANCHEZ, JR., Claimant
WCB Case No. 92-12986
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Gunn.

The SAIF Corporation requests review of Referee Thye's order that set aside a Director's order finding claimant ineligible for vocational assistance. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Finding that OAR 436-120-025(1)(b) conflicts with ORS 656.340(6)(b)(B)(iii), the Referee declined to give the rule effect and found that the Director exceeded his statutory authority by applying the rule. On this basis, the Referee set aside the Director's order and remanded this matter to the Director for re-determination of eligibility for vocational services. As an alternative basis for setting aside the Director's order, the Referee found that even if the rule did not conflict with the statute, the Director abused his discretion by finding that claimant was not employed as a full-time, permanent employee at the time of his injury.

We first consider whether OAR 436-120-025(1)(b) conflicts with ORS 656.340(6)(b)(B)(iii). ORS 656.340(6)(b)(B)(iii) provides that "suitable employment" means 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)(a)(B) provides in part that " . . . [f]or other than full-time, permanent employment, suitable wage is determined as described in OAR 436-120-025." OAR 436-120-025(1)(b) provides:

> "Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage."

It is axiomatic that administrative rules must be consistent with an agency's statutory authority. An 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). Here, we do not agree with the Referee's conclusion that OAR 436-120-025(1)(b) conflicts with ORS 656.340(6)(b)(B)(iii). Rather, the Director's rule merely explains how wages are to be calculated where the worker's "regular employment" is seasonal or temporary. OAR 436-120-025(1)(b). We do not construe OAR 436-120-025(1)(b) as altering, amending, enlarging, or limiting the terms of ORS 656.340(6)(b)(B)(iii). Thus, we conclude that the rule is not inconsistent with ORS 656.340 and the Director did not violate a statute by applying OAR 436-120-025(1)(b) to the instant case.

Having found that OAR 436-120-025(1)(b) is not inconsistent with the statute, we now address the rule's applicability to this case. Although the Referee made a finding that claimant typically worked as a roofer during the dry seasons and collected unemployment compensation during the remainder of the year, he also concluded that the Director abused his discretion by concluding that claimant was other than a full-time permanent employee. SAIF contends that the Referee exceeded his authority under ORS 656.283(2) by rejecting the Director's finding that claimant was not employed on a permanent, full-time basis at the time of his injury. SAIF further contends that, regardless of whether the Referee had authority to modify the Director's factual findings, the evidence preponderates in favor of the Director's finding that claimant was not a permanent, full-time employee.

In Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993), the Court held that, in reviewing a Director's vocational assistance decision under ORS 656.283(2), a referee is entitled to independently find facts based upon a hearing at which the parties develop a record. Noting that the Director's procedure did not provide the claimant a quasi-judicial hearing, or result in a reviewable record, the Colclasure Court concluded that the procedure before the referee comported with the hearing and decisional process required in a contested case, while the Director's procedure did not. The Court held that when reviewing a Director's order under ORS 656.283(2), a referee conducts a hearing, develops a record and finds facts from which he or she determines whether the Director's order survives review, while the Board reviews the record developed by the Referee. Id. at 537.

Here, as in Colclasure, the Director's review procedure did not include a quasi-judicial hearing, or result in a reviewable record. However, we find that the hearing before the Referee satisfied the procedures required in a contested case. Accordingly, applying the holding of Colclasure to this case, we conclude that the Referee was entitled to conduct a hearing, develop a record, find facts and determine whether the Director's order survived review.

Although we reject SAIF's contention that the Referee lacked authority to make findings which differed from those of the Director, we nonetheless find that the record developed by the Referee supports the Director's conclusion that claimant was a seasonal employee rather than a full time, permanent employee. We base our conclusion on the following reasoning.

Claimant did not testify at the hearing. The only evidence concerning claimant's employment history comes from the testimony and report of vocational consultant Adele Bostwick. Based on her interview with claimant, Ms. Bostwick reported that claimant had worked for the employer at injury off and on since 1979 and that he typically worked during the dry seasons and then collected unemployment compensation during the remainder of the year. (Ex. 22-2; Tr. 5-6). Based on this undisputed evidence, we conclude that claimant was a seasonal employee at the time of his injury.

We contrast this decision with our recent holding in Leslie R. Ledford, 46 Van Natta 2 (1994). In Ledford, we held that the Director erred by finding, based on conversations with two employer representatives, that the claimant's employment was "seasonal." The employer representatives in Ledford had indicated that the employer frequently laid off new employees, that there was no guarantee of permanent full-time work at the time of hire, and that a layoff was imminent for the claimant. On Board review, we concluded that whether the claimant would have been laid off was speculation. We further concluded that the most persuasive evidence concerning whether the claimant was a full-time permanent employee was the claimant's credible testimony.

The claimant in Ledford testified that at the time of hire, he understood that the position was a permanent 40-hour a week job. He further testified that he was not informed that the project was a one time project or a series of short term projects or that his employment would come to an end on a certain date. Although the claimant was told of an impending cut back after he was hired, he was not told that he would be laid off.

Based on this testimony, we found that the claimant in Ledford was a full-time permanent employee rather than a seasonal employee. Thus, we concluded that the factual situation in Ledford did not warrant the application of OAR 436-120-025(1)(b). Instead, we used the claimant's at-injury wage as a full-time permanent employee to determine a suitable wage. Using that wage, we found that the claimant was eligible for vocational assistance and we modified the Director's order to so find.

Here, by contrast, claimant did not testify at hearing and the most persuasive evidence concerning his employment pattern is the testimony and report of vocational consultant Bostwick which was based directly on her interview with claimant. We further note that here, unlike in Ledford, claimant's employment pattern is not based on speculation, but is instead based on claimant's actual pattern of employment over a number of years.

Based on the record developed by the Referee, we find that claimant was a seasonal employee at the time of his injury. Thus, we conclude that the Director did not violate ORS 656.340 by applying OAR 436-120-025(1)(b) to this case. We further conclude that the Director did not abuse his discretion by finding that claimant was other than a full-time, permanent employee. Finally, we conclude that the Referee's hearing satisfied the requirements of a contested case. Accordingly, we affirm the Director's order finding that claimant was not eligible for vocational assistance.

ORDER

The Referee's order dated March 4, 1993 is reversed. The Director's order is reinstated and affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant's regular work was seasonal. I would, instead, conclude that claimant's entitlement to vocational assistance should be determined based upon his regular job as a full-time roofer at the time of his injury.

ORS 656.340(6) provides:

> "(6)(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 and suitable employment with the employer at the time of injury and the worker has a substantial handicap to 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."

Here, the record indicates that claimant's regular work was as a roofer and that he was employed full time at the time of his injury. (Ex. 2). "Suitable employment" for claimant should be employment that produces a wage within 20 percent of that currently being paid for roofers. If claimant's regular employment as a full-time roofer was used, claimant would likely be eligible for vocational services.

OAR 436-120-025(1)(b) provides an arbitrary formula for determining wages for workers whose "customary employment pattern" is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected." However, under the statute, claimant's prior employment pattern is not relevant. Rather, what is relevant under the statute is the wage that is currently being paid for claimant's regular employment. To determine what a worker's "regular employment" is we should look to the job the worker actually performs rather than consult a rule for determining a temporary disability rate.

In addition, it is unfair and contrary to the legislature's intent in enacting ORS 656.340(6) to penalize construction trade workers, such as claimant, by denying them vocational assistance because their high paying jobs are largely available only during the dry part of the year. After a serious industrial injury, these construction trade workers are unlikely to be able to obtain employment which pays as much as their jobs at injury without vocational re-training. This cannot have been the intent of the legislature.

I conclude that claimant's "regular employment" should be his work at the time of his injury, rather than his previous "pattern" of employment. Because I would modify the Director's order to find that claimant is entitled to vocational services, I respectfully dissent.

March 8, 1994 Cite as 46 Van Natta 374 (1994)

In the Matter of the Compensation of
MERRY E. FRANKLIN, Claimant
WCB Case No. 92-14761
ORDER DENYING RECONSIDERATION
Willner & Heiling, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On December 30, 1993, we issued an Order on Review that: (1) vacated a Referee's order which had affirmed a Director's order finding that claimant was not entitled to vocational assistance; and (2) remanded claimant's vocational assistance claim to the Director for consideration of the adoption of a temporary rule regarding the establishment of claimant's base wage under OAR 436-120-025(2). On February 10, 1994, we received claimant's request that "the Board resume jurisdiction of this case and effect a remedy for claimant." To the extent that claimant's request can be interpreted as a motion for reconsideration of our December 30, 1993 order, the motion is denied.[1]

Before further addressing claimant's request, we offer the following background information. While locked out from her regular employment as a bus driver, claimant was compensably injured while working as a temporary shuttle driver for another employer. As a result of her injury, claimant was physically unable to return to bus driving activities. When the self-insured employer rejected her subsequent request for vocational assistance, claimant sought Director review. The Director denied her request, reasoning that she had not established a "substantial handicap to employment." See ORS 656.340(6)(b)(B)(iii). In reaching this conclusion, the Director applied OAR 436-120-025(1)(b), which pertains to a worker whose customary employment is periods of seasonal or temporary employment followed by periods of unemployment. The Referee affirmed the Director's order.

In our December 30, 1993 order, we found that, since claimant's only temporary work was that as the shuttle driver, her "customary" employment "pattern" was not seasonal or temporary employment followed by periods of unemployment as described in OAR 436-120-025(1)(b). Merry E. Franklin, 45 Van Natta 2441 (1993). Determining that there was no rule regarding the calculation of claimant's base wage which applied to her situation, we noted that OAR 436-120-025(2) provides that the Director may prescribe additional standards for establishing a base wage. In light of such circumstances, we held that the Director had violated a rule by applying OAR 436-120-025(1)(b). See ORS 656.283(2). Moreover, relying on Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538, 542 (1993), we reasoned that we had implicit authority to remand the claim to the Director for consideration of adoption of a rule under OAR 436-120-025(2).

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[1] We recognize that this decision is issuing prior to the completion of the supplemental briefing schedule which was established in response to claimant's request. We have taken this action for essentially three reasons. One, in light of ORS 656.295(8), we are without authority to reconsider our December 30, 1993 decision. Two, for us to await supplemental arguments concerning this vocational assistance dispute will only further delay its resolution. Finally, any supplemental arguments can be addressed to the Referee who will eventually consider claimant's new hearing request.

Neither party petitioned the Court of Appeals for judicial review of our decision. Instead, on February 1, 1994, the Director (through the Workers' Compensation Division) announced that the Department "has not accepted jurisdiction over this matter." Contending that the Board has the authority "to effect a remedy," the Department "respectfully disagree[d] with the position that the Workers' Compensation Board has the authority to remand a case to the Director." In light of the Department's announcement, claimant has requested "that the Board resume jurisdiction of this case and effect a remedy for claimant."

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, our December 30, 1993 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its issuance. Consequently, we are without authority to reconsider our prior decision because it has become final by operation of law. See ORS 656.295(8); International Paper v. Wright, supra; Fischer v. SAIF, supra. Accordingly, insofar as claimant's request can be interpreted as a motion for reconsideration of our December 30, 1993, the motion must be denied.

Notwithstanding our denial of claimant's request as a motion for reconsideration, her request to "effect a remedy" can also be interpreted as a request for hearing on the Director's February 1, 1994 refusal to take further action. This interpretation is based on the following reasoning.

Although not expressly phrased in such a manner, the Director's announcement is essentially a decision not to exercise the Director's authority to adopt a rule under OAR 436-120-025(2) and to adhere to the Director's prior order finding that claimant was not entitled to vocational assistance.[2] Inasmuch as this decision by the Director affects claimant's right to receive, or the amount of, compensation, it is a matter concerning a claim. ORS 656.704(3). As such, claimant is entitled to request a hearing to contest that decision under ORS 656.283(1), which will be reviewed pursuant to the review standard set forth in ORS 656.283(2). Lee Sigler, 46 Van Natta 212 (1994). The lack of a statement explaining the parties' rights of appeal from the Director's decision does not prevent claimant from contesting that decision. See Glen D. Roles, 42 Van Natta 68 (1990) (The lack of a statement explaining the parties' rights of appeal from a referee's order did not invalidate that order).

In accordance with the aforementioned interpretation, we refer claimant's request to the Hearings Division (New Requests / Docketing Section) with instructions to assign claimant's request a new WCB Case Number and to schedule that request for hearing in the normal course of business.

IT IS SO ORDERED.

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[2] In light of the Director's refusal to take further action, the record for development concerning this new hearing request may likely be similar to the record developed regarding the Director's prior order. Nevertheless, since this new hearing request is arising from the Director's subsequent vocational assistance decision, each party is entitled to present testimonial and documentary evidence regarding this subsequent decision.

Finally, because the Director has chosen not to exercise his authority to adopt an additional "base wage" rule under OAR 436-120-025(2), it would appear that "remand" to the Director is no longer a viable option. Thus, in all likelihood, the future hearing may be confined to a determination of: (1) whether the Director's decision to adhere to a calculation of claimant's "base wage" under OAR 436-120-025(1)(b) withstands the review standard set forth in ORS 656.283(2); and (2) if the Director's decision does not withstand such a review standard, what "base wage" rule (full-time permanent job or otherwise) is applicable.

In the Matter of the Compensation of
RANDY R. PUGH, Claimant
WCB Case Nos. 92-04193, 92-02591, 92-02592, 92-02593, 92-02590 & 92-06461
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation requests review of Referee Mongrain's order that set aside its compensability and responsibility denials of claimant's occupational disease claim for his bilateral hearing loss condition. In his brief, claimant contends that a penalty should be assessed for Liberty's allegedly unreasonable denial of compensability. On review, the issues are compensability, responsibility and penalties. We affirm.

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.

Responsibility

We adopt the Referee's Conclusions and Opinion on the issue of responsibility, with the following supplementation.

On review, Liberty contends that the "standards" for measuring permanent impairment set forth a method of establishing hearing loss. Liberty argues that pursuant to the measurements provided for in the "standards," claimant's hearing loss has not increased while Liberty was on the risk. Liberty contends that it follows that Liberty is not responsible for claimant's condition.

We do not agree that the "standards" provide a method for determining responsibility. The "standards" are applicable in rating a claimant's permanent disability, but a determination of responsibility is derived from either the statute or the case law.[1] Here, we conclude that the Referee properly relied upon the last injurious exposure rule. Furthermore, we agree with the Referee's conclusion that Liberty has failed to prove that an earlier carrier was solely responsible for causing claimant's hearing loss condition, or that it was impossible for claimant's work with Liberty's insured to have caused the condition. Accordingly, we affirm the Referee on the issue of responsibility.

Penalties

On review, claimant contends that, in light of the medical evidence and SAIF's concession of compensability, a penalty should be assessed for Liberty's denial of compensability. However, there is no evidence that the penalty issue was raised in claimant's hearing request or at hearing. Accordingly, because the issue was not previously raised, we decline to consider it for the first time on review. See Mavis v. SAIF, 45 Or App 1059 (1980).

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[1] We find such an approach to be consistent with our decision in James F. Plummer, 45 Van Natta 1477 (1993). In Plummer, we were not persuaded by a carrier's argument that the claimant did not have measurable hearing loss as defined under the "standards." We concluded that the critical determination concerning compensability of an occupational disease claim remains whether the claimant has proven that his work activities were the major contributing cause of his bilateral hearing loss condition. Plummer, supra. Consequently, although the present case involves the "standards" argument in the context of responsibility, we conclude that where responsibility is at issue and the last injurious exposure rule applies, the test remains whether Liberty can prove that an earlier carrier was solely responsible for causing claimant's hearing loss condition, or that it was impossible for claimant's work with Liberty's insured to have caused the condition.

Claimant is entitled to an assessed attorney fee for services on review, to be paid by Liberty. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,000 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 case (as represented by claimant's respondent's brief), the complexity of the issues 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 issue.

ORDER

The Referee's order dated September 21, 1992, as amended by the September 23, 1992 and September 28, 1992 orders, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
DARRELL W. VINSON, Claimant
WCB Case Nos. 91-05363, 91-08114, 91-08115 & 91-04982
ORDER ON REMAND (REMANDING)
Schneider, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys
David L. Runner (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. SAIF v. Vinson, 125 Or App 684 (1994). The court has reversed that portion of our prior order, Darrell W. Vinson, 45 Van Natta 140 (1993), which affirmed and adopted the Arbitrator's Order on Remand that set aside SAIF's denial of claimant's "new injury" claim for a low back condition and upheld Crawford and Company's (Crawford) denial of claimant's aggravation claim for the same condition. Citing SAIF v. Drews, 318 Or 1 (1993), the court has remanded for reconsideration.

Claimant sustained a compensable low back injury on October 25, 1986, while employed by Amity Hardware and Repair (Amity), insured by Crawford and Company (Crawford). The claim was closed by Determination Order on November 12, 1987, with an award of 15 percent unscheduled permanent disability.

In August 1988, claimant began working for DeJong Products, Inc. (DeJong), insured by the SAIF Corporation. Claimant experienced severe back pain on March 12, 1991, while operating a metal drill. An acute low back sprain was diagnosed. Claimant filed a "new injury" claim with SAIF and an aggravation claim with Crawford.

Both carriers denied responsibility for claimant's low back condition. Thereafter, both agreed to the issuance of an order pursuant to ORS 656.307. The only substantive issue at hearing was responsibility for claimant's low back condition.

The Arbitrator found that claimant's condition subsequent to the March 1991 incident involved the same area of claimant's anatomy as previously injured. See ORS 656.308(1). Reasoning that ORS 656.005(7)(a)(B) was applicable to a determination of responsibility under ORS 656.308, the Arbitrator held that Crawford had failed to sustain its burden of proving that a "new compensable injury" had occurred. Specifically, the Arbitrator found that the March 1991 incident was not the "major contributing cause" of claimant's disability and need for medical treatment. Responsibility for claimant's low back condition remained with Crawford.

On review, we remanded to the Arbitrator for a determination of the responsible carrier in light of our decision in Rosalie S. Drews, 44 Van Natta 36 (1992). Darrell W. Vinson, 44 Van Natta 967 (1992). In Drews, we held that ORS 656.005(7)(a)(B) was not applicable in a responsibility context. Accordingly, the Arbitrator was instructed to apply a "material contributing cause" standard in determining the responsible carrier. In her Order on Remand, the Arbitrator found SAIF responsible for a new compensable injury in March 1991 after applying the material causation standard. The Board affirmed and adopted that portion of the Arbitrator's order regarding the responsibility issue. Darrell W. Vinson, 45 Van Natta 140 (1993).

Citing SAIF v. Drews, supra, the court reversed our order and has remanded for reconsideration. SAIF v. Vinson, supra. We now proceed with our reconsideration.

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 Jack W. Sanford, 45 Van Natta 52 (1993).

In her Order on Remand, the Arbitrator shifted responsibility for claimant's low back condition on the basis of a "material contributing cause" standard. Subsequent to the Arbitrator's order, however, the Supreme Court has ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). SAIF v. Drews, supra. Thus, to establish a "new compensable injury" under ORS 656.308, Crawford must prove that the March 12, 1991 incident was the "major contributing cause" of claimant's need for medical treatment.

Because the Arbitrator applied a "material contributing cause" standard, we find that this claim was not analyzed under the applicable legal standard. Because we only review questions of law, we must again remand for a determination of which carrier is responsible when the correct rule of law is applied. See ORS 656.307(2); Patsy B. Marty, 44 Van Natta 139 (1992).

Accordingly, the Arbitrator's Order on Remand dated June 19, 1992 is vacated. This matter is remanded to Arbitrator Nichols for further action consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRETT D. ADAIR, Claimant
WCB Case No. 92-16196
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Garaventa's order that upheld the self-insured employer's denial of a back injury claim. The sole issue on review is compensability. We reverse.

FINDINGS OF FACT

We adopt the findings in the Referee's "Findings of Fact" section. We make the following additional findings.

On or around August 7, 1993, claimant reported to his dispatcher that he had injured his back while unloading his truck. The dispatcher told claimant to report the incident to Carol Zarzana, the employer's workers' compensation claims manager. Claimant spoke with Ms. Zarzana by phone on August 12, 1992, at which time claimant indicated that he hurt his back at work. Ms. Zarzana approved the further use of a "lumper" to help claimant unload his truck. Ms. Zarzana's approval of a "lumper" is only required for workers' compensation cases. Claimant experienced ongoing back pain up to the time he first received medical treatment on November 16, 1992. Claimant did not engage in any fight or assault during the period between his work injury and his first medical treatment.

FINDINGS OF ULTIMATE FACT

Claimant injured his low back while unloading his truck on August 7, 1992. This work injury was a material contributing cause of claimant's low back disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The outcome of this case turns on the accuracy of the history claimant provided to Dr. Stringham, the treating physician. Dr. Stringham's unrebutted opinion that claimant's condition is work related is based on claimant's history of the onset of back pain on August 7, 1992, while unloading boxes of soap and detergent from his truck.

The Referee concluded that claimant had not proven that he injured his back at work on that date. The Referee based her decision on inconsistencies in claimant's story, rather than his demeanor at hearing. When the issue of credibility concerns the substance of claimant's testimony, not just the demeanor of the witnesses, the Board may make its own determination regarding credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Even if claimant lacks credibility in regard to certain matters, he can still meet his burden of proof if the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984). We conclude that the record as a whole supports the history claimant gave Dr. Stringham.

Claimant testified that he first developed back pain on August 7, 1992, while unloading boxes of soap and detergent from his truck. Claimant further testified that he reported the injury to his dispatcher on the day it occurred, and reported a work injury to Ms. Zarzana, the employer's workers' compensation manager, a few days later. Claimant's testimony is consistent with Dr. Stringham's history and other documented reports of the injury.

In particular, the employer's own records establish that claimant reported a sore back to his employer on August 7, 1992, and that the employer authorized a "lumper" to help claimant on that date and on five other occasions over the next month. We are aware that Ms. Zarzana testified that she had no documentation that claimant told her in August that his injury was work related. However, she acknowledged that she assumed claimant had contacted her in August 1992 to report a workers' compensation claim. Ms. Zarzana also testified that she had approved a "lumper" for claimant in August 1992 because her approval was required in workers' compensation cases. Finally, Ms. Zarzana indicated that she did not process the claim in August 1992 because claimant did not seek medical care, not because he had not reported the injury as work related.

We recognize that claimant did not seek medical care for his injury until mid-November 1992, after he was terminated by the employer. However, claimant plausibly explained that he did not seek treatment before that time because he was able to continue driving truck, and the employer was providing a "lumper" for unloading. There is no evidence in the record refuting claimant's testimony that he experienced ongoing low back pain up to the time he sought medical care. To the contrary, the employer's continued authorization of a "lumper" throughout the month following the reported injury supports claimant's testimony of ongoing low back problems.

We are aware that claimant has not been a model employee. In particular, claimant lied to the employer regarding the reason he had not returned to work or contacted the employer in October 1992. However, claimant explained at hearing that he told this story because it was easier than explaining his stressful personal problems. Moreover, this matter and claimant's overall work record have no direct bearing on the issue presently before us.

In summary, we conclude that the record as a whole supports the history claimant gave Dr. Stringham. Accordingly, we conclude that Dr. Stringham's opinion is based on an accurate history and establishes a compensable back injury.

Claimant was represented by counsel at hearing and 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 concerning the compensability issue is $2,500, 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 the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 9, 1993 is reversed. The self-insured employer's denial is set aside, and the claim is remanded to the employer for further processing according to law. For services at hearing, claimant's attorney is awarded $2,500, payable by the employer.

In the Matter of the Compensation of
JAMES P. BIRDWELL, Claimant
WCB Case No. 92-15768
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Lipton's order that affirmed the Order on Reconsideration that awarded 20 percent (64 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," as modified and supplemented.

Claimant's at-injury job title was Production Worker. At the time of the compensable injury, claimant had been performing work as a Metal-Fabrication-Shop Helper.

Based on the physical demands of claimant's job at injury, his prior strength was "heavy."

Claimant has the residual functional capacity (RFC) to perform "medium" work.

The occupation assigned the highest specific vocational preparation (SVP) category met by claimant based on the jobs he performed during the ten years preceding the time of determination is as a production supervisor. The SVP for a production supervisor is 8.

CONCLUSIONS OF LAW AND OPINION

The Referee found that inasmuch as claimant had returned to his usual and customary work, he was entitled to a value of zero for the adaptability factor (which negates the other non-impairment values). See former OAR 436-35-310(2); OAR 436-35-280(6) (WCD Admin. Order 6-1992). In light of his finding, the Referee affirmed the Order on Reconsideration that awarded claimant 20 percent unscheduled permanent disability, based on impairment alone.

Claimant became medically stationary after July 1, 1990, and made a request for reconsideration pursuant to ORS 656.268. Therefore, the applicable standards are those in effect on the date of the August 14, 1992 Determination Order. OAR 438-10-010, 436-35-003(2) (WCD Admin. Order 6-1992).[1]

Claimant contends that while his at-injury job title was Production Worker (DOT 609.685-018, strength medium), at the time of the injury he had been working as a Metal-Fabrication-Shop Helper (DOT 619.686-022, strength heavy). The employer concedes that claimant had been performing work

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[1] We note that subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

"outside of" his job description moving objects weighing up to 150 pounds. Nevertheless, the employer argues that because claimant's current restrictions do not prevent him from returning to either job, claimant's at-injury job title should be utilized to determine his adaptability factor.

Under the applicable standards (see WCD Admin. Order 6-1992), the adaptability factor is based on a comparison of the prior 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 requirements listed in former OAR 436-35-300(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the SVP category assigned by the DOT.

Accordingly, because the adaptability factor is based upon strength demands, we find it reasonable to consider both claimant's job duties and the physical demands of the job he was actually performing at the time of his injury in determining the proper DOT code to be assigned to his job. See William L. Knox, 45 Van Natta 854 (1993) (In determining the proper DOT job description, the Board considers the record as a whole, as it relates to job duties as well as strength demands to find the position which appropriately describes claimant's job at injury).[2] Based on the record and the employer's concession, we find that Metal-Fabrication-Shop Helper most appropriately describes the prior strength demands of claimant's job at injury.

The employer argues that there is no evidence in the record that claimant has permanent restrictions preventing him from returning to work as either a Production Worker or a Metal-Fabrication-Shop Helper. To the contrary, the only opinion concerning claimant's RFC is that of the medical arbiter panel which restricted claimant to lifting up to 50 pounds. Claimant's RFC is, therefore, medium. Former OAR 436-35-270(3)(g)(C). The job of Metal-Fabrication-Shop Helper is at least heavy. See DOT 619.686-022. Accordingly, claimant is entitled to a value of 3 for adaptability. Former OAR 436-35-310(2).

Turning to the other non-impairment factors, claimant is 42 years old. He is entitled to a value of 1 for age. Former OAR 436-35-290(2).

With regard to education, claimant has neither completed high school nor obtained a GED. A value of 1 is allowed. Former OAR 436-35-300(2)(b). The occupation assigned the highest SVP met by claimant based on the jobs he performed during the ten years preceding the time of determination is as a production supervisor. Former OAR 436-35-300(3). This occupation is assigned an SVP of 8, entitling claimant to a value of 1. DOT 619.130-030; former OAR 436-35-300(3)(e). Therefore, claimant is entitled to a value of 2 for the education factor. Former OAR 436-35-300(5).

On review, the parties do not contest the Order on Reconsideration impairment value of 20, for claimant's decreased ranges of motion and surgery. We agree that the award is supported by the medical arbiter panel's opinion; claimant is entitled to an impairment value of 20.

We now assemble the factors to determine claimant's permanent disability. Adding the age (1) and education (2) factors results in a value of 3. Former OAR 436-35-280(4). That value is then multiplied by the adaptability factor of 3, resulting in a value of 9. Former OAR 436-35-280(6). That product is then added to the impairment value of 20, resulting in an award of 29 percent unscheduled permanent disability under the standards.

ORDER

The Referee's order dated March 12, 1993 is modified. In addition to the 20 percent (64 degrees) unscheduled permanent partial disability awarded by the Order on Reconsideration, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total award to date of 29 percent (92.8 degrees) unscheduled permanent partial disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

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[2] Knox applied an earlier version of the standards (WCD Admin. Order 2-1991). However, the portions of the standards which apply to this case (WCD Admin. Order 6-1992) contain the identical language as in former OAR 436-35-270(3) which indicates that prior strength is to be derived from the DOT description. Moreover, under both versions of former OAR 436-35-310(1), the adaptability factor is based on a comparison of the prior strength demands of the worker's job at the time of injury with the worker's maximum residual capacity at the time of determination.

In the Matter of the Compensation of
BRIAN A. BUNDY, Claimant
WCB Case No. 93-00813
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the self-insured employer's denial of claimant's aggravation or occupational disease claim for an unstable low back spondylolisthesis condition; and (2) found that claimant's accepted injury claim was not prematurely closed. On review, the issues are compensability, premature closure, or, alternatively, temporary disability (interim compensation). We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant began working for the employer in 1976 as a warehouseman. His work consists of repetitive heavy lifting.

On May 5, 1989, the employer accepted claimant's claim for a February 10, 1989 disabling low back strain injury. (Ex. 13). The injurious event occurred when claimant leaned over to pick up a box of meat at work[1] and experienced a sudden onset of severe low back pain. Claimant treated conservatively while he was off work for about seven months following the injury.

A February 8, 1990 Determination Order closed the injury claim and awarded temporary disability, 25 percent unscheduled permanent disability, and 5 percent scheduled disability.

Claimant returned to work in the fall of 1989 in the employer's supply department, where he did less heavy lifting than before. However, by the end of December 1990, claimant was again doing heavy lifting work. His low back symptoms worsened gradually and he sought treatment again in March 1991. He filed an aggravation claim which the employer denied. After a hearing, a referee ordered the claim accepted. (Ex. 68). In so doing, the referee noted that claimant's congenital spinal defect, low back spondylolisthesis, had not been worsened by the 1989 work injury. (Ex. 68A-3).

A July 21, 1992 Notice of Closure closed claimant's 1991 aggravation claim and awarded additional temporary and permanent disability. (See Exs. 91, 93, 96, 101, 106).

In September 1992, claimant's back symptoms worsened again and he sought treatment from Dr. Misko, who became his treating physician. Dr. Misko suspected unstable spondylolisthesis with irritation of the L5 root. He ordered flexion-extension films which showed "translatory motion, marked, at L5-S1, with a 6 mm translation during extension in relation of L5 to the sacrum." (Ex. 99-2; see Ex. 116). Thereafter, Dr. Misko diagnosed unstable spondylolisthesis and filed a November 2, 1992 claim (on claimant's behalf), requesting authorization for low back surgery. (See Exs. 102, 104).

On January 12, 1993, the employer issued a denial which states that the claim for treatment for lumbosacral spondylolisthesis is unrelated to the accepted February 10, 1989 strain injury. (Ex. 109). Claimant requested a hearing.

FINDINGS OF ULTIMATE FACT

As of the July 21, 1992 Notice of Closure, no material improvement in claimant's compensable low back strain condition was reasonably anticipated.

Claimant's repetitive work activities for the employer, including the February 10, 1989 injurious incident, were the major contributing cause of a pathological worsening of claimant's preexisting low back condition.

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[1] The injury has been loosely described as a "lifting injury," even though claimant never actually lifted that particular box.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the employer characterized its January 12, 1993 denial as a "partial denial" of treatment for spondylolisthesis.[2] (Ex. 109).

The Referee's order states that the issue is the compensability of claimant's spondylolisthesis condition. The employer argues that claimant's injury did not worsen the preexisting spondylolisthesis. Claimant contends that the unstable spondylolisthesis is work related. Our review of the record reveals that the compensability of claimant's unstable spondylolisthesis condition, as an aggravation of the 1989 injury or as a "new" occupational disease, was thoroughly litigated. In this regard, we note that the Opinion and Order mentions claimant's occupational disease theory, (see O&O p. 3), and the theory is argued by the parties on review. Under these circumstances, we conclude that the compensability of claimant's unstable spondylolisthesis condition (as an aggravation or as an occupational disease) is properly before us on review.

Compensability

The Referee found that claimant's current unstable low back spondylolisthesis condition is not compensably related to his accepted condition, a 1989 low back strain. Although we agree that claimant's accepted injury is not primarily responsible for his present need for low back surgery, we conclude that the claim for an unstable spondylolisthesis condition at L5-S1 is compensable, based on the following reasoning.

Claimant's current condition is not the same as the low back strain which the employer accepted in 1989. Although the congenital spondylolisthesis condition preexisted claimant's almost 15-year work exposure, his disabling unstable spondylolisthesis condition at L5-S1 developed during his work exposure; i.e., claimant's preexisting condition worsened as a result of his work activities..

The medical evidence establishes that an unstable spondylolisthesis condition is not unexpected, considering claimant's preexisting defect and his repetitive work activities. The evidence also indicates that claimant's low back problems have worsened gradually during recent years. Under these circumstances, the present claim is properly analyzed as an occupational disease. See James v. SAIF, 290 Or 343 (1981). Thus, in order to prove entitlement to benefits for his unstable spondylolisthesis condition, claimant must establish that repetitive work activities were the major contributing cause of a worsening of his preexisting condition. See ORS 656.802(1)&(2).

Claimant had no low back problems prior to his work exposure which began in 1976. Thus, the question becomes whether claimant's low back condition worsened during or following his work exposure. We conclude that it has.

Dr. Misko, current treating physician, persuasively explains the mechanism of claimant's low back disease process as follows. Heavy lifting at work and the 1989 work injury caused a weakening of the ligamentous structures surrounding the spondylolisthesis. This weakening, in turn, caused the translatory motion seen on the stress films in 1992 and claimant's disabling symptoms. (Exs. 112, 117). Dr. Goldberg, former treating physician, and Dr. Ferrante, treating chiropractor, agreed with Dr. Misko's opinion and conclusions. (Exs. 119, 121; see also Ex. 120-4).

The evidence contrary to the treating physicians' opinions is provided by Dr. Duff, orthopedist, and Dr. Phipps, neurologist. They opined that claimant's spondylolisthesis is unchanged, based on their review of static films and a lack of "objective evidence" of worsening. (Ex. 108-4). However, inasmuch as Drs. Duff and Phipps do acknowledge the current instability of claimant's spondylolisthesis, without suggesting that this instability preceded claimant's work exposure and symptoms, we find their conclusion that the condition has not changed unpersuasive. (See Ex. 124).

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[2] The denial is "partial" only in the sense that the employer does not seek to escape liability for the low back strain condition which it accepted in 1989.

On this evidence, we find that claimant's preexisting low back condition at L5-S1 became increasingly unstable, and correspondingly symptomatic, with his work exposure. Because claimant now requires surgery, due to the mechanical instability of his condition, this change (becoming unstable) amounts to a pathological worsening of the preexisting condition. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (The medical evidence need not consist of a specific incantation of magic words). We further find that claimant's worsened low back condition is established by objective findings, i.e., his symptoms and the stress films.

The remaining question is whether claimant has proven that his work exposure was the major contributing cause of his worsened low back condition. ORS 656.802.

Drs. Misko, Goldberg, and Ferrante agree that claimant's work activities were the major contributing cause of his unstable L5-S1 spondylolisthesis condition. (Exs. 112, 117, 119, 121, 128). Their conclusions regarding causation are supported by the opinions of Drs. Flemming and Ordonez. (Exs. 116, 120).

The employer argues that the opinions of Drs. Fuller, Utterback, Duff, and Phipps persuasively rebut the opinions of Drs. Misko, Goldberg, Ferrante, Flemming and Ordonez. We disagree.

Dr. Fuller examined claimant in 1992 and performed a file review in 1993. Dr. Fuller opined that problems such as claimant's are a "foreseeable consequence" of his condition and "any activity which requires repetitive movement of [the pars interarticularis]." (Ex. 125-1). However, because no off-work repetitive back activities are indicated, Dr. Fuller's opinion does not weigh against the claim.

Although Dr. Utterback acknowledged that claimant's "unfortunate choice of occupation" was an "aggravating influence," he nonetheless concluded that claimant's work was not the major cause of his current condition. (Ex. 122; see Ex. 12-2). Because Dr. Utterback's conclusion lacks adequate explanation, it is not persuasive.

As we have stated, we do not find Drs. Duff and Phipps' opinion that claimant's spondylolisthesis condition has not changed to be persuasive. Dr. Phipps also opined that claimant's work activities since 1976 were not the primary cause of claimant's current problems, reasoning that claimant's work had been modified "early on" and claimant's symptoms had nonetheless progressed. (Ex. 123). However, because claimant did perform heavy repetitive lifting work for the employer for nearly fifteen years, Dr. Phipps' conclusion is unpersuasive as it is based on an inaccurate history. Finally, although Dr. Duff eventually acknowledged Dr. Misko's description of the mechanism of claimant's progressive problems, Dr. Duff disagreed without explanation. (Ex. 124-1). Under these circumstances, we conclude that the persuasive opinions of claimant's treating physicians are essentially unrebutted. Accordingly, we conclude that claimant has carried his burden of proving that his work activities were the major contributing cause of his unstable L5-S1 spondylolisthesis condition. Consequently, the claim is compensable as to the unstable L5-S1 spondylolisthesis only.

Premature closure

We adopt the Referee's opinion on the premature closure issue, with the following supplementation.

On April 8, 1993, Dr. Goldberg opined that claimant "would not have been medically stable [on June 23, 1992] if surgery is considered to be an improvement at this point in time[.]" (Ex. 128).

Surgery was not recommended until after Dr. Misko examined claimant in September 1992. (See Exs. 99, 102). Consequently, Dr. Goldberg's 1993 opinion, which is based on Dr. Misko's October 1992 surgery request, does not relate back to claimant's condition on July 21, 1992 when the claim was closed. See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). Accordingly, we agree with the Referee that claimant has not proven that there was a reasonable anticipation of material improvement in claimant's low back strain condition when the claim was closed. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985).

Temporary Disability/Interim compensation

Claimant seeks continuing temporary disability, if his aggravation claim was prematurely closed. Alternatively, claimant requests temporary disability beginning as of Dr. Misko's October 16, 1992 request for authorization for surgery.

We hold herein that claimant's aggravation claim was not prematurely closed. Consequently, claimant is not entitled to additional temporary disability compensation under that claim. Moreover, because no physician has authorized time loss since claimant's prior claim was properly closed, claimant has not established entitlement to temporary disability compensation under his current low back claim. See ORS 656.273(6).

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 $5,000, 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 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 May 13, 1993 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's January 12, 1993 denial of claimant's occupational disease claim for an unstable lumbosacral spondylolisthesis condition at L5-S1 is reversed. The denial is set aside and the claim for an unstable lumbosacral spondylolisthesis condition at L5-S1 is remanded to the employer 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 a $5,000 attorney fee.

March 9, 1994 Cite as 46 Van Natta 385 (1994)

In the Matter of the Compensation of
JOHN G. CARBERY, Claimant
WCB Case No. 93-01696
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The self-insured employer requests review of Referee Crumme's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral hearing loss; and (2) assessed an attorney fee of $2,000 for claimant's attorney's services at hearing. 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 exceptions and supplementation. We do not adopt finding number 5 or the Referee's "Discussion of Findings."

Dr. Hodgson, otolaryngologist, examined claimant regarding his hearing loss on October 27, 1992. (Exs. 3, 9). Dr. Hodgson diagnosed a bilateral hearing loss and recommended bilateral hearing aids.

Dr. Mettler, otolaryngologist, examined claimant for the employer on December 8, 1992. (Exs. 5, 7, 10).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established a compensable occupational disease regarding his bilateral hearing loss. The employer argues that claimant failed to meet his burden of proof regarding the cause of his bilateral hearing loss. We agree with the employer.

The record contains no evidence of a specific injury. Instead, the evidence supports hearing loss due to a gradual onset. (Exs. 9, 10). Therefore, we analyze the condition as an occupational disease. Valtinson v. SAIF, 56 Or App 184 (1982).

In order to prove compensability of his bilateral hearing loss as an occupational disease, claimant must show that his work exposure is the major contributing cause of the hearing loss condition or its worsening. ORS 656.802; Aetna Casualty v. Aschbacher, 107 Or App 494, 502 (1991); Richard L. Leathers, 44 Van Natta 138 (1992). 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). Claimant has the burden of proof on this issue. ORS 656.802(2).

The cause of claimant's bilateral hearing loss is a complex medical question. Therefore, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The record contains medical opinions from two physicians regarding the cause of claimant's hearing loss. Dr. Mettler, otolaryngologist, examined claimant for the employer on December 8, 1992. (Exs. 5, 7). Dr. Mettler initially concluded that claimant had no hearing loss. (Ex. 7). However, in a later check-the-box opinion, Dr. Mettler agreed that claimant has a hearing loss but attributes the loss to normal presbycusis. (Ex. 10).

Dr. Hodgson, otolaryngologist, examined claimant on October 27, 1992, diagnosed bilateral sensorineural hearing loss and recommended bilateral hearing aids. At that time, Dr. Hodgson made the conclusory statement that claimant's hearing loss was "most likely due to traumatic noise exposure around jet aircraft." (Ex. 3).

In a March 30, 1993 letter to claimant's counsel, Dr. Hodgson again stated that the major contributing cause of claimant's hearing loss was noise exposure with the employer for 26 years. (Ex. 9-1). However, Dr. Hodgson also noted that claimant reported using ear protection during all exposures to noise at the employer. Dr. Hodgson noted that he did not have information regarding the amount of attenuation the ear protectors afforded claimant, nor did he have sound level measurements regarding the level of noise exposure claimant experienced at work. (Ex. 9-2).

Dr. Hodgson explained that, if the noise was sufficiently attenuated by the ear protectors so that the noise level was reduced to 85 decibels, the exposure would not be considered injurious. He noted that one could be exposed to that level of noise for eight hours a day and have no probability of traumatic noise exposure. In addition, he explained that claimant's flight line work did not involve constant exposure to noise. Instead, the noise levels to which claimant was exposed would only be intermittent, which would reduce the effect even more. (Ex. 9-2). Finally, Dr. Hodgson noted that claimant's hearing loss is not typical of hearing loss caused by noise exposure. Id.

Given the multiple qualifications that Dr. Hodgson attached to his opinion, and the fact that he acknowledged that his opinion was formed on the basis of inadequate information, we do not find Dr. Hodgson's opinion persuasive. The record contains no other medical opinion that supports claimant's contention that his hearing loss is caused by noise exposure at work.

On this record, claimant has failed to meet his burden of proving that his work exposure is the major contributing cause of his bilateral hearing loss. Because the claim is not compensable, claimant is not entitled to attorney fees at hearing or on review. Therefore, we do not address the employer's argument that the Referee's award of assessed attorney fees was excessive.

ORDER

The Referee's order dated June 3, 1993 is reversed. The self-insured employer's December 28, 1992 denial is reinstated and upheld. The Referee's award of an assessed attorney fee of $2,000 is reversed.

In the Matter of the Compensation of
TOM D. DEVLIN, Claimant
Own Motion No. 94-0062M
OWN MOTION ORDER

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 April 20, 1993. The employer asks the Board to authorize the reopening of claimant's claim.

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 a January 17, 1994 letter, Dr. Serbu, claimant's treating neurosurgeon, stated that claimant had been to the emergency room several days prior with acute severe pain in his low back. On examination, Dr Serbu opined that claimant had an acute lumbar strain. Dr. Serbu recommended claimant stay off work for one week. No recommendations for surgery or hospitalization are in the record.

Here, 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 the employer's request to reopen the claim. Accordingly, we deny the request for own motion relief. Id.

The employer's gratuitous payment of temporary disability compensation is permitted by statute and is within the employer's discretion. See ORS 656.278(4); Allen E. Orton, 42 Van Natta 924 (1990). However, inasmuch as those benefits were not properly paid pursuant to the Board's Own Motion authority, the Board shall not authorize the reopening of the claim. ORS 656.278(1)(a).

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD G. HARROUN, JR., Claimant
WCB Case Nos. 93-00801, 93-00426, 93-00425, 92-15542 & 92-12807
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Corporation (Liberty) requests review of Referee Black's order which: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's denial for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the same employer since 1976, initially as a millwright, and more recently, as a log truck driver. Claimant sustained a low back injury in June 1977, while insured by SAIF. As a result of this injury, in January 1978, claimant underwent an L4-L5 hemilaminectomy.

Claimant reinjured his low back in January 1983. Dr. Campagna performed a microlumbar discectomy, on January 26, 1983, for recurrent nerve root compression L5 left secondary to extruded L4 disc. SAIF accepted this injury as a new injury claim.

On July 8, 1992, while working in the employer's equipment shop, claimant developed increased low back pain and left leg pain, and sought treatment for the pain on July 17, 1992. Dr. Louie diagnosed a left L5 nerve root contusion without herniation and prescribed conservative treatment.

Liberty denied the claim on September 23, 1992 and notified claimant that SAIF was a potentially responsible insurer. On December 11, 1992, SAIF issued its disclaimer of responsibility and claim denial.

Relying on the Court of Appeals decision in Drews v. SAIF, 117 Or App 596 (1993), the Referee found that claimant sustained a new compensable injury under ORS 656.308 to shift responsibility to Liberty.

Subsequent to the Referee's order, the Supreme Court held that "the major contributing cause" limitation contained in ORS 656.005(7)(a)(B) did apply in the responsibility context to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. SAIF v. Drews, 318 Or 1 (1993). The Supreme Court reasoned that such a determination is made regardless of whether the preexisting condition was compensable. Id. Thus, responsibility shifts to a subsequent employer only if a new injury is the major contributing cause of the disability or need for treatment.

The Supreme Court reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer only if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the major contributing cause, the Supreme Court further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

In this case, the evidence establishes that claimant has had a chronic and recurring condition at the same level since 1977 and that claimant's work exposure in July 1992 merely caused a symptomatic worsening of his preexisting condition. Following his 1983 surgery, claimant continued to experience dull low back pain, but no leg pain. He sought occasional chiropractic treatment and occasionally missed a couple days of work. (Tr 10-11, 17-18). After working in the employer's shop in July 1992, claimant's back pain worsened and he developed leg pain. He testified that the leg pain was identical to the leg pain before the 1983 surgery but not as severe. (Tr 23). Surgery was not recommended and claimant improved with conservative treatment.

Dr. Louie, claimant's treating physician, felt that claimant had a recurrence of back and leg pain. He opined that the major contributing cause of claimant's current low back condition was his previous surgery and subsequent work activities. (Ex. 63).

Dr. Bernstein, neurologist, and Dr. Donahoo, orthopedic surgeon, examined claimant on November 13, 1992. They described claimant's current low back condition as a mild L5 radiculopathy, due to his July 1992 incident and to his scar formation from his previous surgeries. They opined that the July 1992 incident constituted an aggravation of claimant's preexisting condition and that, although his current work activities were a major contributing cause for continuing treatment, claimant's original injury was the major contributing cause of his current condition. (Ex. 66). We construe their opinion as establishing that claimant's July 1992 incident combined with his preexisting compensable condition and that his preexisting condition was the major contributing cause of his current condition.

Therefore, the preponderance of the medical evidence establishes that claimant's preexisting compensable condition, for which SAIF is responsible, is and remains the major contributing cause of his current low back condition. Inasmuch as SAIF has failed to establish a new compensable injury while Liberty was on the risk, responsibility does not shift to Liberty.

Given our conclusion that SAIF remains responsible for claimant's condition, we need not address Liberty's contention that SAIF waived its responsibility defense by its failure to issue a timely disclaimer of responsibility.

Although claimant's counsel has requested an assessed attorney fee for services on review, we conclude that such a fee is not warranted in this case. ORS 656.382(2) authorizes attorney fees when claimant's right to compensation is at risk of disallowance or reduction. Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Claimant's compensation was at risk of reduction as a result of Liberty's appeal since claimant's temporary disability rate under Liberty's claim was higher than under SAIF's claim. However, claimant's compensation was reduced as a result of our decision finding SAIF responsible. Under such circumstances, claimant is not entitled to an assessed fee under ORS 656.382(2). Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990); see generally, Dolly S. Mack, 43 Van Natta 389 (1991); Riley E. Lott, Jr., 43 Van Natta 209 (1991).

ORDER

The Referee's order dated April 30, 1993 is reversed. Liberty's denial is reinstated and upheld. The SAIF Corporation's December 11, 1992 denial is set aside and the claim is remanded to SAIF (under the 1983 injury claim) for processing according to law. The Referee's assessed attorney fee award shall be paid by the SAIF Corporation, rather than Liberty.

March 9, 1994 Cite as 46 Van Natta 389 (1994)

In the Matter of the Compensation of
DAVID A. KAMP, Claimant
WCB Case No. 93-01585
ORDER ON REVIEW
Bettis & Associates, Claimant Attorneys
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of Referee Mills' order that: (1) awarded 18 percent (27 degrees) scheduled permanent disability for loss of use of claimant's right forearm, whereas an Order on Reconsideration had awarded none; and (2) awarded 16 percent (51.2 degrees) unscheduled permanent disability for right shoulder and neck conditions, whereas an Order on Reconsideration had awarded none. On review, the issues are extent of permanent disability (scheduled and unscheduled). We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee found claimant to be a credible witness and that finding is not challenged on review. Based on claimant's credible testimony that he was able to return to truck driving work following a 1985 neck and shoulder injury, the Referee concluded that the 1985 injury had resolved at the time of the October 24, 1991 compensable injury (the subject of the present dispute). Thus, again based on claimant's credible testimony, the Referee further concluded that claimant's current neck, right shoulder and bilateral hand problems are related to the October 24, 1991 compensable injury. We reverse.

Claimant's credibility may be relevant in evaluating the causes contributing to his impairment. However, because the 1985 injury has been identified as a potential contributing cause of claimant's current problems by medical experts (see Exs. 4, 10-4), this is not a "simple" case and causation is a complex medical question which must be resolved by medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993). Under these circumstances, claimant's testimony alone is insufficient to establish that the impairment claimed is related to the 1991 compensable injury. Moreover, even if claimant's testimony regarding the effects of his 1985 neck and shoulder injury is relevant and material, we would nonetheless conclude that his claim for permanent disability compensation fails, based on the following reasoning.

Unscheduled disability

Claimant argues entitlement to two 5 percent unscheduled permanent impairment awards for chronic conditions of the neck and right shoulder. See OAR 436-35-320(5). In this regard, claimant relies on Dr. Smith's diagnoses of chronic cervical strain and chronic impingement of the right shoulder and Dr. Lundquist's limitations against lifting or pushing and pulling over 50 pounds or carrying 25 pounds frequently.

OAR 436-35-320(5) provides that a "worker may be entitled to unscheduled chronic condition impairment when 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." The rule requires medical evidence of at least a partial loss of ability to repetitively use the body area, due to the compensable injury. Glenda R. Linderman, 46 Van Natta 47 (1994); see Donald E. Lowry, 45 Van Natta 1452 (1993).

In this case, Dr. Smith's diagnoses of chronic neck and shoulder conditions does not mean that claimant has lost (or partially lost) his ability to use his neck and right shoulder repetitively. Moreover, Dr. Lundquist explained that claimant's work limitations were imposed to avoid the likelihood of reinjury. In other words, Dr. Lundquist does not say that claimant's restrictions are related to the 1991 work injury. See Curlee Fisher, 44 Van Natta 2171 (1992). There is no other medical evidence arguably suggesting that claimant has chronic neck and right shoulder conditions which render him unable to repetitively use those body areas or that he has other injury-related unscheduled impairment under the standards. Consequently, claimant has not established entitlement to an unscheduled permanent disability award under the standards. See OAR 436-35-320(5); 436-35-270(2) (WCD Admin. Order 6-1992).

Scheduled disability

The Referee found claimant entitled to a permanent disability award for lost grip strength, based on claimant's credible testimony and Dr. Smith's opinion that claimant is "able to grip 55 units on the right, 85 on the left." (Ex. 10-3).

However, because no physician identified nerve injury causing lost strength or measured claimant's grip strength using the "0 to 5" muscle grading system, as required by OAR 436-35-007(14) and 436-35-110(7) & (8), any loss of strength which claimant may have is not ratable under the standards. See Jimmie H. Prewitt, 44 Van Natta 2546 (1992); James H. Smith, 43 Van Natta 2817 (1991). Thus, claimant has not established entitlement to a scheduled permanent disability award.

ORDER

The Referee's order dated June 3, 1993 is reversed. The Order on Reconsideration is reinstated and affirmed.

In the Matter of the Compensation of
THEODORE W. KINDER, Claimant
WCB Case Nos. 92-12317 & 92-12316
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jim Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Referee Crumme's order which set aside its denial of claimant's aggravation claim for a left knee condition. On review, the issue is aggravation.

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

Claimant has a left knee condition for which a claim was accepted and closed by Determination Order on July 23, 1991, with an award of 5 percent scheduled permanent disability for the loss of the use or function of the left leg (knee). This award was based on claimant's prior left knee surgery. (Ex. 7-2). Claimant was determined to be medically stationary on May 21, 1991. Claimant's treating physician at the time, Dr. Gillespie, had released claimant for regular work without restrictions.

In October 1991, claimant sought treatment from an orthopedic surgeon, Dr. Carpenter, for continued pain and weakness in his knee. Dr. Carpenter's examination revealed less than full extension of the left knee, as well as popping and patellar crepitus.

On November 11, 1991, Dr. Carpenter requested authorization for surgery, a request that was ultimately referred to the Director for resolution. Claimant continued to report weakness in his left leg, resulting in give-way and significantly impaired mobility.

In the meantime, claimant requested reconsideration of the July 23, 1991 Determination Order; his request was based, in part, on an objection to the impairment findings used to rate his disability. Dr. Carpenter stated on November 22, 1991 that claimant's left knee condition had not objectively and materially worsened.

As part of its reconsideration of the July 23, 1991 Determination Order, the Department appointed a medical arbiter, Dr. Smith, to examine claimant on January 23, 1992. Dr. Smith's report was submitted to and considered by the Department. The Department's Order on Reconsideration of February 10, 1992 increased claimant's scheduled permanent disability award for the left leg (knee) to 20 percent scheduled disability after considering the medical arbiter's findings. The Order on Reconsideration was not appealed.

On April 6, 1992, Dr. Carpenter continued to recommend arthroscopic surgery even though claimant's examination was unchanged. Dr. Carpenter also restricted claimant to sedentary employment and noted that claimant was not medically stationary.

On September 9, 1992, the Department issued its Proposed and Final Order concerning the dispute over claimant's surgery, determining that surgery on claimant's left knee was inappropriate. On January 11, 1993, SAIF denied claimant's aggravation claim. The Referee set aside SAIF's aggravation denial, finding that the last arrangement of compensation was the July 23, 1991 Determination Order and that claimant's left knee condition had worsened since that date.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. Perry v. SAIF, 307 Or 654 (1989). An aggravation has two components: causation and worsening. We must first determine whether claimant's condition is compensable. If it is compensable, then we determine whether the compensable condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992), aff'd, Gray v. SAIF, 121 Or App 217 (1993).

When a compensable injury has combined with a preexisting condition to cause disability or a need for medical treatment, claimant has the burden of proving that the compensable injury is the major contributing cause of the resultant condition. ORS 656.005(7)(a)(B); Tektronix v. Nazari, Inc., 117 Or App 409, mod, 120 Or App 590 (1993); Jaime G. Tellez, 45 Van Natta 2065, 2066 (1993).

The Referee found that claimant's compensable left knee injury had combined with preexisting degenerative conditions. He then held that claimant had proved that his compensable left knee injury remained the major contributing cause of his resultant disability and need for treatment. We agree with the Referee that the opinion of the current treating physician, Dr. Carpenter, is more persuasive on the causation issue than those of the other physicians involved in the claim. Taylor v. SAIF, 75 Or App 583, 585 (1985). Accordingly, we agree with the Referee's reasoning as to causation. Claimant's current left knee condition is compensable.

However, our analysis does not end there, because claimant must still prove his compensable left knee condition has worsened. The Referee held that he had done so. We agree.

To prove a compensable worsening of his scheduled condition, claimant must show that he is more disabled; i.e., that he has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993); Edna M. Anderson, 44 Van Natta 2093, 2094 (1992).

To resolve the issue of whether claimant sustained a compensable worsening, it is first necessary to determine when the last arrangement of compensation occurred. The Referee determined that the last arrangement of compensation was the Determination Order of July 23, 1991. SAIF contends that the last arrangement was the Order on Reconsideration of February 10, 1992, citing Grace M. Nyburg, 44 Van Natta 1875 (1992).

In Nyburg, we concluded that the last arrangement of compensation was a Determination Order, not a subsequent Order on Reconsideration. We reasoned that, because the Order on Reconsideration considered only evidence presented up to the date of the Determination Order, the date of the issuance of the Determination Order was the claimant's "last opportunity to present evidence" regarding her condition. Therefore, in order to establish a worsened condition, we held that the claimant had the burden of proving that her condition had worsened since the issuance of the Determination Order. 44 Van Natta at 1876.

However, in Lindon E. Lewis, 46 Van Natta 237 (1994), we concluded that our reliance on a claimant's "last opportunity to present evidence" regarding his condition is ill-suited for conducting an aggravation analysis under the current statutory scheme, which provides for mandatory reconsideration by the Department. We held that evidence regarding the "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). Here, claimant alleges that his condition worsened after issuance of the July 23, 1991 Determination Order, but before the February 10, 1992 Order on Reconsideration.

Accordingly, we find that the last award or arrangement of compensation was the July 23, 1991 Determination Order. In order to establish a compensable aggravation claim, claimant must prove that his compensable left knee condition has worsened since the July 1991 Determination Order. Lindon E. Lewis, supra. Thus, under Lewis, the "baseline" for determining whether claimant's condition has compensably worsened is his medically stationary condition up to and including the July 1991 Determination Order.

We now proceed to a determination of whether claimant's left-knee condition has worsened since the July 1991 Determination Order. We conclude that it has.

When claimant was declared medically stationary in May 1991, he was released for regular work without restriction. (Ex. 6). In contrast, in April 1992, Dr. Carpenter, claimant's attending physician, restricted claimant to sedentary employment. (Ex. 36). In his other medical reports, Dr. Carpenter reported reduced range of motion, patellar crepitus and weakness. (Exs. 9, 10, 12). Such findings were not documented when claimant was declared medically stationary in May 1991. (Ex. 6). While Dr. Carpenter stated that claimant's left knee condition had not objectively worsened in November 1991, his medical reports as a whole establish a worsening of claimant's left knee condition, especially when compared to claimant's status prior to the July 1991 Determination Order.

Moreover, claimant's award of permanent disability in the Determination Order was based on his left knee surgery and was not made in contemplation of future waxing and waning of symptoms. (Ex. 7-2). Therefore, claimant does not have to establish that his worsening is more than a waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8).

Accordingly, we conclude that the medical evidence does establish that claimant sustained a compensable worsening of his left knee condition since the last arrangement of compensation. He has, therefore, proved a compensable aggravation claim.

Since claimant has prevailed over SAIF's appeal, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering all 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 attorney's services on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have considered the time devoted to this case (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated May 27, 1993 is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,000 for services on review, payable by SAIF.

March 9, 1994 Cite as 46 Van Natta 393 (1994)

In the Matter of the Compensation of
LIONSO NAVARRO, Claimant
WCB Case No. 92-12189
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Westerband, Haynes, and Hall.

Claimant requests review of Referee Michael Johnson's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for chronic sinusitis, asthma, and nasal polyps. On review, the issue is compensability.

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

The Referee relied on the opinions of Dr. Montanaro, M.D., assistant professor with the Allergy and Clinical Immunology Division of the Department of Medicine at the Oregon Health Sciences University (OHSU). He examined claimant for SAIF and performed a record review. (Exs. 38, 46, 47).

Claimant argues that the Referee should have relied on the opinions of some of his treating physicians. However, we find that this case involves expert analysis rather than expert external observations, and therefore, the status of "treating physician" confers no special deference in this case. Allie v. SAIF, 79 Or App 284 (1986). Furthermore, we agree with the Referee that Dr. Montanaro's reports are better reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Claimant argues that the Referee erred in stating that Dr. Claridge, treating physician, deferred to Dr. Montanaro's opinion. We agree that there is no evidence that Dr. Claridge deferred to Dr. Montanaro's opinion. However, as the Referee found, the record does not indicate any area of special expertise for Dr. Claridge, and he practices in what appears to be a general practice clinic. Therefore, we give greater weight to the opinion of Dr. Montanaro, than we do to that of Dr. Claridge, based on Dr. Montanaro's expertise as an allergist. See Abbott v. SAIF, 45 Or App 567, 661 (1980).

Dr. Baker, treating allergist, performed allergy tests on claimant, which were negative. (Exs. 13, 16). Dr. Baker at first opined that claimant had an underlying polyp disease as a possible cause of his asthma problems. (Ex. 16). Later, he opined that claimant's asthma was "most likely work-related." Id. However, he ultimately concurred with Dr. Montanaro's opinion that the cause of claimant's pansinusitis, asthma, and nasal polyps was an infection rather than any exposure at work. (Exs. 38, 42-1, -2). In addition, Dr. Baker opined that, while the exposure to irritants at work is "an exacerbation of an underlying condition," he did "not feel that this exposure has caused the asthma or has caused a material worsening in the condition." (Ex. 42-1).

Dr. Lundeberg, treating otolaryngologist, also concurred with Dr. Montanaro's report. (Ex. 39). In doing so, Dr. Lundeberg stated that "with regard to [claimant's] sinus condition and Dr. Montanaro's report[,] I would concur with Dr. Montanaro's report. I can comment only to [claimant's] sinus condition and do not have any opinion with regard to his asthma condition." Id.

Later, in a telephone conversation summary submitted to him by claimant's attorney, Dr. Lundeberg agreed that his opinion was that "the wood dust at the mill has probably caused the pathological worsening of [claimant's] sinuses, in that the constant irritation over the years probably caused the slow onset of the sinusitis and subsequent polyposis." (Ex. 45-4). This represents a change of opinion from his prior concurrence with Dr. Montanaro's report, which related claimant's respiratory problems, including the sinus condition, to an infection rather than to any work place exposure.

However, instead of explaining this change of opinion, Dr. Lundeberg denied concurring with any opinion relating to the cause of the sinus condition. (Ex. 45-5, -6). Dr. Lundeberg stated that he had only concurred with Dr. Montanaro's history and his opinion that sensitivity to molds did not result in claimant's condition. Id. However, Dr. Lundeberg's recantation does not comport with his earlier concurrence, in which he clearly stated that he concurred with Dr. Montanaro's opinion with regard to claimant's sinus condition but that he did not have an opinion with regard to the asthma condition. Given these inconsistencies in Dr. Lundeberg's opinion, we do not find it persuasive.

Dr. Bilstrom, treating allergist, opined that the major contributing cause of claimant's asthma, chronic sinusitis, and nasal polyps is his industrial exposure at the mill. (Ex. 43-5, -6). In reaching this opinion, Dr. Bilstrom found that claimant was allergic to dust mites and strongly allergic to alternaria, a mold spore that he felt would be highly concentrated in a lumber mill. (Exs. 43-3, -4, 6).

However, the allergy tests conducted by Dr. Baker were negative. (Exs. 13, 16). In addition, allergy tests conducted by OHSU were negative for fir and pine and were "weak" for alternaria. (Ex. 36-4). In discussing these tests, Dr. Montanaro opined that claimant "has manifest mild precipitin reactions against common molds which are commonly seen in normal individuals. He has not manifest hypersensitivity disease...." (Ex. 38-5, -6). Dr. Montanaro concluded that the allergy tests conducted by Dr. Baker and OHSU "did not indicate the presence of mold allergy or allergy to other inhalant antigens." (Ex. 47-1).

In challenging Dr. Montanaro's opinion, Dr. Bilstrom argued that: (1) Dr. Montanaro did not challenge allergy as being a factor in claimant's condition; (2) the skin tests were not repeated; and (3) an IgE level was not obtained, which, if elevated, would suggest allergic etiology. (Ex. 44-2). However, as noted above, Dr. Montanaro opined that allergy was not a factor in claimant's condition and noted that the allergy tests performed by Dr. Baker and OHSU supported his opinion. (Ex. 38-5, -6). In addition, repeat allergy tests were performed at OHSU as part of Dr. Montanaro's examination. (Exs. 36-4, 46, 47). Furthermore, an IgE level was obtained, and the level was within the normal range. (Ex. 36-4).

Dr. Bilstrom also stated that Dr. Montanaro gave no plausible alternative mechanism for claimant's chronic sinusitis and other respiratory problems. (Ex. 43-7). However, Dr. Montanaro opined that a bacterial infection caused claimant's respiratory problems. (Exs. 38-5, 46, 47). We agree with the Referee that the record is replete with evidence that claimant received ongoing treatment for chronic sinus infection.

On the other hand, Dr. Bilstrom does not address or dispute the relationship of any bacterial infection to claimant's sinusitis, asthma, and nasal polyp conditions. Furthermore, Dr. Bilstrom bases his opinion regarding causation primarily on his finding that claimant has allergies to mold spores and dust mites. (Exs. 43, 49). However, given the negative allergy tests performed by Dr. Baker and OHSU, we do not find that a preponderance of the medical evidence establishes that claimant has allergies to mold or other inhalent antigens.

Finally, Dr. Bilstrom raised an alternative possibility that wood smoke, fumes from pine and softwood resins (colophony), and other low molecular weight irritants acting in concert with high molecular irritants, such as wood dust, in the work place could have caused claimant's problems. (Ex. 44-3). However, a possibility is not sufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

On this record, we agree with the Referee that claimant has not established, by a preponderance of evidence, that exposures at work were the major contributing cause of his respiratory conditions.

ORDER

The Referee's order dated May 14, 1993 is affirmed.

Board Member Hall dissenting.

I would rely on the opinion of Dr. Bilstrom, claimant's treating allergist, to find that claimant has established that exposures at work were the major contributing cause of his respiratory conditions. For that reason, I respectfully dissent.

First, I do not find this to be a case involving expert analysis rather than expert external observations. To the contrary, observations regarding claimant's respiratory condition over time are critical in this case. As claimant's treating allergist, Dr. Bilstrom is in a much better position to observe claimant's respiratory condition than is Dr. Montanaro, who examined claimant only once for SAIF. The Board generally gives greater weight to the conclusions of a treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons not to defer to Dr. Bilstrom.

Second, I find that Dr. Montanaro bases his opinion on an inaccurate history. The majority adopted the Referee's analysis that, if one finds the cause of claimant's chronic sinusitis, that leads to the cause of his other respiratory conditions -- the asthma and nasal polyps. I agree with that analysis, but Dr. Montanaro opines that the chronic sinusitis is caused by chronic bacterial infections. However, there is no history of chronic infection prior to claimant's onset of sinusitis in September 1989. Therefore, Dr. Montanaro's opinion is based on an inaccurate history. On that basis alone, his opinion is unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, supra. Dr. Bilstrom, on the other hand, persuasively opines that the cause of claimant's chronic sinusitis is his exposure to dust and allergens at work.

Based on Dr. Bilstrom's persuasive opinion, I would find that claimant's respiratory conditions are compensable.

March 9, 1994 Cite as 46 Van Natta 395 (1994)

In the Matter of the Compensation of
JOHN E. NOYER, Claimant
WCB Case No. 92-14248
ORDER ON REVIEW (REMANDING)
David B. Lowry, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Galton's order that set aside its denial of claimant's claim for a neck and mid back injury. On review, the issue is compensability. We remand.

FINDINGS OF FACT

On June 19, 1992 claimant sought treatment from Dr. Rockwell, D.C. Claimant reported neck and mid back pain. Claimant also reported chest pain and digestive problems to Dr. Rockwell. Dr. Rockwell referred claimant to Dr. Litchfield. In turn, Dr. Litchfield referred claimant to Dr. Norby and Dr. Belza, both neurologists. An independent medical examination was scheduled with Dr. Smith, an orthopedic surgeon; however, claimant did not attend the examination. Dr. Smith reviewed claimant's medical records and issued a report.

On September 10, 1992, SAIF issued the following denial:

"SAIF Corporation is in receipt of your claim for an alleged injury to your back and chest which occurred on or around June 18, 1992 while employed at [its insured].

"In order for a claim to be compensable under Oregon Workers' Compensation law, there must be specific objective findings which support the condition diagnosed by your attending physician. In reviewing the information in your file, I cannot determine any objective findings in regards to your injury. Furthermore, you have not complied with numerous attempts to obtain additional information from you. Therefore, SAIF Corporation must deny your claim."

Claimant requested a hearing, which was held on April 2, 1993. Claimant did not personally appear at the hearing, but appeared through his attorney.

At the hearing, SAIF contended that claimant had failed to establish legal causation since claimant's hearsay statements contained in the medical reports are the only evidence that his injury occurred at work. In response, claimant's attorney moved for a postponement in order to take claimant's testimony. The motion was denied.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the record contained objective findings of an injury. Reasoning that SAIF's denial was based on the grounds that there were no objective findings of an injury, the Referee concluded that SAIF's "only affirmable basis for the denial" was wrong and he set aside SAIF's denial of claimant's injury claim.

Relying on Froylan L. Zurita, 43 Van Natta 1382 (1991), aff'd Zurita v. Canby Nursery, 115 Or App 330 (1992), SAIF contends that claimant has failed to establish legal causation since claimant's hearsay statements contained in the medical reports are the only evidence that his injury occurred at work.

In Zurita, supra, we held that a claimant's statements to a physician for purposes of medical diagnosis or treatment are admissible to the extent that they are reasonably pertinent to diagnosis or treatment, even though they are hearsay and the claimant is not available at hearing for cross-examination. However, we also held, in Zurita, that while there may be a strong indicia of reliability in a hearsay report of how injuries occurred, there is no such indicia of reliability in hearsay reports of where injuries occurred.

Here, SAIF denied the claim on the grounds that the injury was not established by medical evidence supported by "objective findings."[1] When it became apparent to SAIF's attorney that claimant was not at the hearing (except through counsel), SAIF asserted the "legal causation" argument under Zurita. In response, claimant's counsel moved for a continuance to allow claimant's testimony to be provided on the question of legal causation. We understand the Referee to have ruled that SAIF was bound by the limited terms of its denial, and therefore, the question of "legal causation" was untimely raised at hearing.

In examining a referee's decision concerning a motion for continuance of the hearing, we review for an abuse of discretion. See Jack J. Ford, 43 Van Natta 1643 (1991); Mark G. Smith, 43 Van Natta 315 (1991). After conducting our review in accordance with this standard, we conclude that the motion should have been granted.

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[1] The dissent argues that the reference to an "alleged injury" in SAIF's denial represents a contention that the claim did not arise out of the course and scope of claimant's employment. We disagree with such an interpretation. To begin, a notice of denial "shall specify the factual and legal reasons for denial." OAR 438-05-055. SAIF's assertion that the claim lack objective findings satisfies this "specificity" requirement. However, we do not consider SAIF's general reference to an "alleged injury" in its denial sufficient to provide the requisite factual and legal specificity envisioned by the rule. We draw further support for this conclusion from SAIF's counsel, who stated at hearing that "[t]he denial was actually issued on lack of objective findings . . ." (Tr. 9).

The Board's rules for the conduct of hearings and case law demonstrate a practice and policy of allowing denials to be amended at hearing to raise new issues. OAR 438-06-031; James S. Franklin, 43 Van Natta 2323 (1991). Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 438-06-091(3). The appropriate way for that party to respond initially to a new issue raised that he is not prepared to address is to request a continuance. (Id).

Here, the denial only raised a medical question that did not require claimant's presence or testimony at hearing: i.e., whether the medical evidence of the injury was supported by "objective findings." The question of legal causation SAIF raised for the first time at hearing was a new issue, effectively an amendment of its denial. We conclude that the amendment should have been allowed by the Referee, consistent with Board policy.[2] We also conclude, on the other hand, that claimant's request for continuance to respond to the new issue raised, should have been granted as well.

Accordingly, we will remand this case to the Referee to allow claimant an opportunity to offer testimony or other evidence on the question of "legal causation," for the purpose of developing the record fully on that question. SAIF shall have an opportunity to cross-examine claimant or any other witness, as well as present rebuttal evidence (testimonial or documentary). As the party bearing the burden of proof, claimant shall have the opportunity to present final rebuttal evidence. The Referee may conduct these further proceedings consistent with this order in any manner that he finds will achieve substantial justice. ORS 656.283(7). The Referee shall then issue a final appealable order.

ORDER

The Referee's order dated April 9, 1993 is vacated. This matter is remanded to Referee Galton for further proceedings consistent with this order.

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[2] The dissent contends that this decision will have far reaching implications regarding the framing of carrier denials and the continuing viability of the Zurita holding. We do not share such concerns. Any message from this decision would be that if a carrier intends to deny a claim based on a "legal causation" theory, it should specify the factual and legal reasons for such a denial. Not only would such a denial be in accordance with OAR 438-05-055, but it would achieve the goals mentioned by the dissent (reduce the time required for clarifying the disputed issues). Moreover, a "specific" denial would preclude the likelihood of possible continuances granted to permit a "non-appearing" claimant to respond to a subsequent "amended denial" at the scheduled hearing. Had such a specific "legal causation" denial been issued in this case, a continuance would not have been warranted when SAIF raised the Zurita holding because there would have been no amendment to the appealed denial.

Board Member Hall specially concurring.

I agree with the analysis by the Referee and by Members Westerband and Gunn that SAIF's denial was based on the perceived lack of objective findings only. Ultimately, I would affirm the Referee and would not allow an oral amendment of the denial at hearing, thus eliminating the need for a remand. However, because my analysis regarding the denial itself is more in keeping with Members Westerband and Gunn, I vote with them.

OAR 438-05-055 provides that "[i]n addition to the requirements of ORS 656.262, the notice of denial shall specify the factual and legal reasons for denial." In this way, the parties know exactly what issues to prepare to litigate. In this regard, I disagree with the dissent that the majority holding would create problems with drafting denials. As I view the situation, the carrier is already required to do what the majority is articulating. Further, we have the Court of Appeals' decision in Tattoo v. Barrett Business Services, 118 Or App 348, 351 (1993), which held that "employers are bound by the express language of their denials." Here, I would have done as the Referee did -- deny the oral amendment and resolve the denial based on the existence or lack of objective findings.

OAR 438-06-031, allows amendments to the hearing request of the issues up to the date of the hearing. This has been construed to allow liberal amendments generally and has resulted in liberal postponements. However, we must always keep in mind that there is a distinction between "pre-hearing" amendments to requests for hearing and oral amendments to denials. The former is permissible under OAR 438-06-031. The latter is not only inconsistent with the aforementioned rule, but it is contrary to the Tattoo holding.

Board Members Haynes and Neidig dissenting.

Because we disagree with the majority's conclusion that this matter should be remanded to allow claimant to present further evidence, we respectfully dissent.

As a procedural matter, there is simply no basis for a remand. ORS 656.295(5) outlines the legal standard. The statute provides that a case may be remanded to the Referee if the Board finds that the record has been "improperly, incompletely or otherwise insufficiently developed or heard by the Referee." In that event the Board may remand the case to the Referee for further evidence taking, correction, or other necessary action.

The majority remands this case on the theory that by arguing that medical exhibits containing hearsay statements of an on-the-job injury should be given little weight in accordance with Zurita, SAIF has "effectively amended its denial" and raised for the first time the issue of legal causation. See Froylan L. Zurita, 43 Van Natta 1382 (1991), aff'd Zurita v. Canby Nursery, 115 Or App 330 (1992). Further, it is the position of the majority that in response to this "new issue" claimant moved to continue the hearing. We do not consider the Referee's rejection of the continuance motion to constitute an abuse of discretion, nor do we find the present record insufficient to conduct our review.

We have great difficulty with the concept that by simply asking the Referee to evaluate the evidence in light of the Zurita holding (which the Referee is bound to do regardless of whether the holding is "raised"), that this can be construed as raising a new issue and effectively amending a carrier's denial. (See Tr. 8). We would require a more explicit statement from a party before going down this road. In any event, the facts simply do not warrant the conclusions reached by the majority.

To begin, the issue at hearing was compensability of an initial injury claim. The denial stated:

> "SAIF Corporation is in receipt of your claim for an alleged injury to your back and chest which occurred on or around June 18, 1992 while employed at [the employer].
>
> "In order for a claim to be compensable under Oregon Workers' Compensation law, there must be specific findings which support the condition diagnosed by the attending physician. In reviewing the information in your file, I cannot determine any objective findings in regards to your injury. Furthermore, you have not complied with numerous attempts to obtain additional information from you. Therefore, SAIF Corporation must deny your claim." (Ex. 10))(emphasis supplied).

Clearly, from the plain language of the document, there were two grounds for issuance of the denial. The first was whether an injury occurred while claimant was employed. The second was the lack of objective findings. Accordingly, it is incorrect for the Referee and the Board to characterize this claim as being denied solely on the basis of no objective findings, and to further conclude that SAIF raised for the first time at hearing legal causation.

But even granting that a "new issue" was raised for the sake of argument, remand is still not appropriate. When claimant asked for a continuance it was for the sole purpose of getting claimant to the hearing and taking his testimony. (Tr. 4-5). SAIF objected to this request. When asked by the Referee what were the grounds for the request, claimant's counsel stated he had been in contact with his client the day before the hearing, but could not explain his failure to appear at the hearing. He speculated that claimant had been unable to find the hearing location. (Tr. 5). Although this discussion took place prior to SAIF's "Zurita" argument, claimant's counsel did not assert that claimant was surprised or prejudiced by SAIF raising this so-called "new issue." Moreover, claimant's counsel did not attribute claimant's non-appearance to a reliance on SAIF's "objective findings" denial and the belief that there had been no need to present claimant's testimony until SAIF's "Zurita" defense.

In other words, claimant never asked for a continuance based on a "new issue" being raised, and no extraordinary circumstances were ever shown to have existed to warrant postponement. OAR 438-06-081; OAR 438-06-091. (Tr. 6). Accordingly, the Referee properly denied the motion. There was no abuse of discretion. Indeed, it would have been improper for the Referee to do anything but what he did; deny the motion and address the merits.

The burden of proving an injury or occupational disease is compensable is upon the worker. ORS 656.266. The only evidence that claimant's injury occurred at work is in the form of claimant's hearsay statements in the medical reports. Although such evidence is admissible for the truth of claimant's statements to the extent that those statements were reasonably pertinent to medical diagnosis and treatment, such evidence is not persuasive evidence concerning where claimant's injuries occurred. See ORS 656.310(2); Zurita v. Canby Nursery, supra; see also Emery R. Miller, 43 Van Natta 1788 (1991) (Statements that an injury happened at work are not reasonably pertinent to the physician's diagnosis and treatment and are not prima facie evidence of the fact asserted). Zurita, supra; Ciriaco Sosa, 43 Van Natta 1713 (1991).

Here, claimant filed an 801 form asserting that he injured his back and neck at work. Although the medical reports constitute prima facie evidence that claimant sustained a back and neck strain injury, the only evidence of where claimant sustained the strain injuries comes from claimant himself who was not present to testify at hearing. Inasmuch as claimant's "out-of-court" statements regarding where the injury occurred are not reasonably reliable, we would conclude that there is insufficient evidence to establish a prima facie case that claimant's back and neck strain occurred in the course and scope of his employment. Therefore, on the merits, we would reverse the Referee's order.

Our ultimate concern is the effect this case will have on the workers' compensation system. In our opinion, it will discourage carriers from specifying the grounds on which their denials will be based. We would predict that, as a consequence of this decision, denials will be written in broad, general language to include legal causation in every instance. In this way, carriers will attempt to avoid the risk that referees will grant "back door" postponements when claimants fail to appear at a scheduled hearing and carriers "raise a Zurita defense."

In other words, the end result of the majority's decision is that denials will either be less specific or so broadly detailed as to list all potential defenses. In either event, such denials will likely culminate in additional time for hearing preparation because each side will be uncertain of each others' particular position or theory. Likewise, these denials will increase the amount of time expended in the hearing as referees seek to clarify the parties' respective positions. Thus, the majority's ruling and the carriers' likely response to that decision will not only add further expense to the litigation process, but will also delay the administration of justice. We believe the system would be better served by encouraging carriers to issue specific denials, thereby streamlining issues and reducing litigation.

The denial in this case is an example of just such a denial. In addition to denying the alleged work injury, the carrier asserted that claimant lacked objective findings to support his claim. In light of such a specific denial, claimant has notice that he must be prepared to establish not only the relationship between his disability and his work activities, but he is also apprised of the need to present medical evidence based on objective findings to support his claim. Since claimant failed to present probative evidence concerning the "causal relationship" issue (by virtue of his failure to appear at hearing), his claim must fail.

Finally, we are also unsure of what remains of the Zurita decision after this case. Zurita addressed the evidentiary issue of what weight to give the hearsay statements of the claimant contained in medical reports that the injury occurred on the job when the claimant fails to appear at hearing but chooses to go forward through counsel. Because the hearsay statements contain little indicia of reliability, the answer to that question, in the absence of the claimant's testimony, is little weight.

The facts here are very similar to those in Zurita. The issue at hearing was an appeal from an initial compensability denial. At the time of hearing, the claimant failed to appear but was represented by counsel. A continuance was not granted. However, unlike the claimant in Zurita, this claimant will not be bound by evidentiary limitations. Instead, notwithstanding claimant's unjustified failure to attend the hearing, he will be allowed to testify at a second hearing on the issue of legal causation.

Clearly, what this case instructs is that where there is some question that the claim was not denied on "course and scope" grounds, claimant fails to appear at a scheduled hearing (for whatever reason), and the carrier requests application of the Zurita holding, the only course for the referee is to continue the hearing in order to afford claimant the opportunity to testify and cure his evidentiary problems regarding legal causation. The inescapable conclusion is that, at least in part, Zurita, has been

overruled sub silentio. Be that as it may, we wish to emphasize the majority's acknowledgment in footnote 2 that Zurita will continue to be applied in those cases where denials specify "course and scope" grounds.

In conclusion, based on the foregoing reasoning, we respectfully dissent.

March 9, 1994 Cite as 46 Van Natta 400 (1994)

In the Matter of the Compensation of
JOHN H. PETERS, Claimant
WCB Case No. C4-00332
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Liberty Northwest, Insurance Carrier

Reviewed by Board Member Haynes and Gunn.

On February 7, 1994, 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 disapprove the proposed disposition.

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 disposition was submitted to us on February 7, 1994. The 30th day following the submission is March 9, 1994. Claimant filed his request for disapproval of the disposition on March 7, 1994. Accordingly, we disapprove the disposition. Id.

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.

March 9, 1994 Cite as 46 Van Natta 400 (1994)

In the Matter of the Compensation of
NANCY P. STRANDE, Claimant
WCB Case Nos. 92-16061 & 92-12875
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of those portions of Referee Peterson's order that: (1) found that claimant had no partial loss of the use of the plantar portion of each foot; and (2) increased claimant's unscheduled permanent disability award for her low back injury to 10 percent (32 degrees), whereas an Order on Reconsideration awarded her 9 percent (28.8 degrees). On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last sentence, for which we substitute the following.

Claimant's residual functional capacity is sedentary/light.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Partial Disability

We affirm the Referee's opinion on this issue and supplement as follows.

The burden of proving the nature and extent of any disability resulting from a compensable injury or occupational disease is upon the worker. ORS 656.266. Scheduled partial disability is determined by rating the permanent loss of use or function of a body part due to an on-the-job injury. ORS 656.214(1)(b); OAR 436-35-010(2). Physical disability ratings shall be established on the basis of medical evidence supported by objective findings by the attending physician, or by other medical providers if concurred in by the attending physician, or by the medical arbiter. ORS 656.245(3)(b)(B) and 656.268(7).

An objective finding may be based on a physically verifiable impairment or on the physician's evaluation of the worker's description of the pain or other sensation he or she is experiencing. See SAIF v. Cruz, 120 Or App 65, 67 (1993); Georgia Pacific Corporation v. Ferrer, 114 Or App 471, 474 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Dr. Bald, the medical arbiter, stated that claimant experienced "subjective decreased sensation to sharp evaluation" in the plantar aspect of the ball of the foot bilaterally. Nevertheless, we conclude that claimant is not entitled to an award for the loss of sensation found by the arbiter.

After reviewing the record, we conclude that there is no medical evidence establishing permanent loss of sensation. Dr. Bald does not indicate that his finding of decreased sensation is permanent. The only loss he identifies as "permanent" involves the low back. See Ex. 27-3. Accordingly, we conclude that claimant failed to establish permanent impairment. She, therefore, is not entitled to an award of scheduled permanent partial disability. OAR 436-35-270(2); SAIF v. Bement, 109 Or App 387 (1991).

Unscheduled Permanent Partial Disability

The Referee awarded 10 percent unscheduled permanent partial disability for claimant's low back. He rated claimant's adaptability value as 2. Claimant does not dispute the age, education or impairment values established by the Referee. She contends only that her rating for adaptability should be 4, based on her ability to perform sedentary work with restrictions, or, alternatively, it should be 3, based on her ability to perform light work with restrictions. We affirm the Referee for the following reasons.

The adaptability factor is based upon a comparison of the highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination as compared to the worker's maximum residual functional capacity at the time of determination. OAR 436-35-310(1). Here, claimant's job title as a Hairdresser is classified as light.. DOT # 332.271-018. Furthermore, we note that the record contains no evidence that claimant had successfully performed a job with a greater strength demand during the previous 10 years than the job she held at the time of injury. Claimant has returned to the same job, but with restrictions.

In the Matter of the Compensation of
MARCHETA M. WEST, Claimant
WCB Case No. 92-00052
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Michael V. Johnson's order that: (1) declined to award additional temporary disability benefits; and (2) declined to assess a penalty for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability benefits, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Facts," except we replace the second paragraph on page two with the following:

In January 1991, claimant (who had suffered a compensable injury) began working as a bookkeeper/office manager under a wage subsidy agreement with another employer (Apple Jacks Produce Market). On September 6, 1991, Business Administrative Services (BAS) assumed administration of Apple Jacks' employees.

During August and September 1991, claimant experienced health problems unrelated to her compensable injury, and took unpaid medical leave from September 6, 1991 through September 10, 1991. Because Apple Jacks was reorganizing and downsizing its operation, claimant's position was eliminated. When claimant sought to return to work, BAS informed claimant that it did not have any work available. Ms. Nagel, co-owner of Apple Jacks, assumed the bookkeeping job duties.

Claimant's vocational rehabilitation (VR) counselor advised BAS that the balance of claimant's wage subsidy reimbursement period was available to BAS. BAS indicated, however, that "reemployment for light, modified or regular-duty as a Bookkeeper/Office Manager with Apple Jacks Mountain Express Produce was not available."

Throughout the fall of 1991, claimant was released to perform only modified sedentary work. Claimant's treating physician neither released claimant to return to her regular work nor declared her medically stationary. Claimant continued to seek work with the assistance of her VR counselor. The employer at-injury did not offer claimant modified work.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The Referee found that claimant's position had not been terminated when she left work on

In this regard, we rely on claimant's testimony, as supported by Ms. Nagel and the contemporaneous vocational rehabilitation records. We specifically find that claimant's lay-off occurred because Apple Jacks no longer had work available within claimant's injury-related limitations. As claimant was unable to perform her regular work due to her compensable injury when her wage subsidy position was terminated by Apple Jacks, the employer at-injury was required to immediately reinstitute the payment of temporary disability compensation. Gray v. SAIF, supra; Carmen Gusman, 42 Van Natta 425 (1990).

Accordingly, we conclude that claimant is entitled to temporary disability benefits from September 11, 1991 until termination is authorized by law (see ORS 656.268(3)), including temporary total disability benefits during any periods claimant had no other income.

Penalty

Claimant is entitled to a penalty up to 25 percent of the amounts due if the employer unreasonably refuses to pay compensation. ORS 656.262(10). Because the employer was required to immediately reinstitute the payment of temporary total disability compensation when claimant's modified job ended, we conclude that the employer unreasonably resisted the payment of compensation. Gray v. SAIF, supra; former OAR 436-60-030(6)(b). Accordingly, we assess a penalty of 25 percent of the temporary disability benefits due through March 10, 1992, the date of hearing. See Warren D. Battle, 45 Van Natta 1169 (1993).

In addition, claimant seeks an attorney fee under ORS 656.382(1). A single unreasonable act cannot be the basis for both a penalty under ORS 656.262(10)(a) and an award of attorney fees under ORS 656.382(1). Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Oliver v. Norstar, Inc., 116 Or App 333 (1993); Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). Consequently, claimant's attorney is awarded one-half of the penalty assessed by this order, in lieu of an attorney fee. ORS 656.262(10)(a).

ORDER

The Referee's order dated February 17, 1993 is reversed. The self-insured employer is directed to pay temporary disability benefits from September 11, 1991 until termination is authorized by law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. A penalty is assessed equal to 25 percent of the temporary disability benefits accruing from September 11, 1991 through March 10, 1992, to be equally divided between claimant and her attorney.

March 9, 1994 Cite as 46 Van Natta 403 (1994)

In the Matter of the Compensation of
GABRIEL ZAPATA, Claimant
WCB Case No. 92-14910
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Podnar's order which upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

This 32-year-old trim line worker filed a claim for injury on July 1, 1992, alleging that he injured his low back when a stool he was sitting on collapsed. At hearing, claimant described the mechanics of the fall, stating that as he attempted to sit on a stool which was about 3-4 feet high, the stool seat collapsed and he fell to the base of the stool. He felt immediate pain in his back, and his foreman took him to a hospital emergency room. (Tr. 6, 10, 14).

Dr. Van Eaton, emergency physician, treated claimant on July 1, 1992. Upon examination, he found lumbar tenderness, diagnosed a low back strain, and prescribed medication and rest. (Ex. 3).

On July 2, 1992, claimant sought treatment from another emergency physician, Dr. Wendler, who found tenderness along the lumbar spine and out laterally, diagnosed a low back strain, and prescribed medication and rest. (Ex. 6).

Claimant began to treat with Dr. Bowman, orthopedist, on July 13, 1992. X-rays, a bone scan and MRI were all normal. (Exs. 7-2, 9, 10a-1). On examination, Dr. Bowman found tenderness in the posterior spinous process of L5 through the sacrum, as well as point tenderness at the coccyx. He prescribed medication and physical therapy, as well as no work for one month. (Ex. 7). Physical therapy was not helpful. (Ex. 10a-1).

On August 10, 1992, Dr. Bowman authorized two more weeks off work, but suspected claimant's major problem at that point was symptom magnification. (Ex. 10a-2).

Dr. Bowman last treated claimant on August 27, 1992, when he opined that claimant "undoubtedly has a soft tissue contusion but I think the patient's primary problem is symptomatic amplification and pain and symptoms of a nonorganic nature." (Ex. 13-1). He released claimant to regular work, but with sitting restricted to no more than one hour at a time. (Exs. 13, 14).

On September 9, 1992, Drs. Hazel and Jessen examined claimant at the insurer's request. They diagnosed "[c]ontusion to the coccyx and possibly to the sacrum by history," but found no evidence of objective findings to support claimant's symptomatic complaints. They further opined, "It is possible that the worker fell to the ground as indicated but sustained no injury as a result of the incident." (Ex. 15-7, -8).

The insurer denied the claim for a low back strain on October 2, 1992. (Ex. 16).

On March 31, 1993, claimant began treating with Dr. Ortiz, who diagnosed osteoarthritis of the back and possible spondyloarthropathy, genetic. (Ex. 19). In April 1993, Dr. Ortiz opined that he did not think claimant's continuing problems were related to his fall at work. He also opined that claimant most probably did sustain a "strain-sprain of the back" as a result of a fall at work on July 1, 1992, which required medical evaluation and treatment. (Ex. 22).

The Referee did not make credibility findings. Claimant testified with the aid of an interpreter.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden to prove, by a preponderance of the evidence, that an accidental injury at work was a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a); 656.266. In addition, claimant must establish the injury with medical evidence supported by objective findings. ORS 656.005(7)(a).

Although the record suggests that, by April 1993, claimant's back problems were due primarily to a genetic condition (more importantly, they were not due to the work injury), the record does not establish that claimant's July 1992 injury combined with a preexisting condition to cause or prolong claimant's disability or need for treatment. Rather, by April 1993, Dr. Ortiz opined that claimant's complaints were no longer caused by the July 1992 work injury. Therefore, ORS 656.005(7)(a)(B) is not applicable, and claimant need not prove that his July 1992 injury was the major contributing cause of his disability and need for medical treatment. See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993); Gary Stevens, 44 Van Natta 1178 (1992).

There is no dispute that claimant fell at work when his stool collapsed, and that he obtained immediate medical treatment. Although there are variations in the record with respect to how far claimant fell (ranging from 2 feet to 4 feet), and whether he fell to the floor or to the base of the stool, we do not find these variations significant with respect to the question of whether claimant sustained an injury to his back. Accordingly, we find that claimant sustained an accidental injury at work.

Furthermore, we find that there is medical evidence of an injury supported by objective findings. Drs. Van Eaton, Wendler and Bowman all made objective findings of an injury when they initially treated claimant, specifically finding lumbar spine tenderness and muscle spasm. All three physicians recommended treatment, and Dr. Bowman also authorized approximately 6 weeks off work.

Although Dr. Van Eaton later wrote that claimant did not show "objective signs of severe trauma," such as ecchymosis, neurological compromise or significant evidence of muscle spasms, we do not find that this letter contradicts the findings he made on the day of claimant's injury. (Compare Exs. 3, 17). On the day of injury, Dr. Van Eaton found only lumbar tenderness, on the basis of which he diagnosed a low back strain. (Ex. 3). That finding is sufficient to constitute an objective finding in support of medical evidence of an injury. See Georgia-Pacific Corp v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Accordingly, we find that Dr. Van Eaton's later letter does not contradict his initial findings in support of a low back strain, and we conclude that those findings are sufficient to constitute objective findings in support of medical evidence.

We do not find that the report of examining physicians, Drs. Jessen and Hazel, contradicts the previous medical reports. Drs. Jessen and Hazel simply found that on the date of their examination, September 9, 1992, claimant had no objective findings to support his subjective complaints. They did not offer an opinion, within reasonable medical probability, regarding whether claimant had objective findings of an injury when he first sought treatment after the July 1, 1992 work incident. (See Ex. 15-8). Gormley v. SAIF, 52 Or App 1055 (1981). Indeed, the examiners' report is consistent with Dr. Bowman's opinion on August 27, 1992, that claimant's then-current pain complaints were not supported by objective findings.

Finally, we find that the preponderance of evidence establishes that claimant's low back condition in July and August 1992 was caused, at least in material part, by his July 1, 1992 work injury. We find that, based on the initial medical reports in July and August 1992, a material causal relationship reasonably may be inferred between claimant's then-current complaints and his fall at work. Furthermore, Dr. Ortiz, claimant's treating physician in April 1993, opined that, based on reasonable medical probability, claimant sustained a low back strain-sprain as a result of his July 1992 fall at work. (Ex. 22-1). The examining physicians did not offer an opinion on causation based on reasonable medical probability. (Ex. 15-8). Therefore, we conclude that claimant has established that his July 1992 work injury was a material contributing cause of his disability and need for medical treatment for his low back condition in July and August 1992.

Accordingly, we conclude that claimant carried his burden of proving the compensability of his low back condition.

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 $3,200, payable by the insurer.[1] In determining a reasonable attorney fee, we have particularly considered the time devoted to the case (as represented by the hearing record, claimant's appellate briefs and claimant's counsel's statement of services on review), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 12, 1993 is reversed. The insurer's October 2, 1992 denial is set aside, and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,200, to be paid by the insurer.

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[1] We note that claimant was represented by an attorney at hearing, but retained a different attorney on review. Thus, it would appear that each attorney is entitled to a share of the attorney fee award. Nevertheless, the insurer is required to pay the entire award to claimant's appellate counsel, claimant's current attorney of record. Thereafter, the manner in which the fee is shared by claimant's current and former counsel is a matter to be decided between the two of them, not this forum. Timothy S. Waggoner, 43 Van Natta 1856 (1991); Fred L. Snider, 43 Van Natta 577 (1991).

In the Matter of the Compensation of
CATHY B. ANDERSON, Claimant
WCB Case No. 92-08981
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Hazelett's order which upheld the SAIF Corporation's denial of her occupational disease claim for a left thumb and wrist condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for a prior employer from March 1990 to May 1991. The work required her to use scissors two full days a week, which caused pain in her left thumb.

Claimant began working as an apartment complex manager for the employer in February 1992. Claimant, who is left handed, also performed maintenance work for the employer.

In March 1992, claimant noticed pain in her left thumb and wrist while polishing mailboxes at work. The pain worsened over the next three weeks as she performed her work duties of vacuuming and mopping. In late April 1992, claimant sought treatment for left thumb pain. Dr. MacDonald diagnosed a left thumb strain and prescribed medication and a splint.

Dr. MacDonald referred claimant to hand surgeon Dr. Nye, who examined claimant on May 7, May 14, and May 28, 1992. X-rays of the left thumb and wrist were taken on May 6, 1992. Dr. Nye diagnosed calcific tendinitis, possibly due to calcium pyro-phosphate deposition disease, and put the left wrist in a cast for a few weeks. Claimant's symptoms subsided and the cast was removed.

Claimant went back to work and noticed a recurrence of the same symptoms while mopping and vacuuming. She returned to Dr. Nye in June 1992 with left thumb pain. Dr. Nye arranged for a rheumatological consultation; however, claimant did not see the rheumatologist. Claimant did not return to Dr. Nye.

On June 25, 1992, SAIF denied the claim for "calcific tendinitis."

On July 28, 1992, claimant sought treatment with hand surgeon Dr. Layman for worsening pain in the left thumb and wrist. Dr. Layman noted that, although Dr. Nye diagnosed calcific tendinitis, the official report of x-rays in May 1992 noted evidence of osteoarthritis at the base of the left thumb. (Ex. 15). Dr. Layman ordered a bone scan, which was taken on August 4, 1992.

Based on results of that scan, Dr. Layman diagnosed capsulitis/tendinitis over the dorsum of the wrist and osteoarthritis of the articulation between the trapezium, trapezoid and the base of the thumb. (Ex. 17). Dr. Layman noted that this condition is not in the same area where Dr. Nye noted calcific tendinitis. Dr. Layman prescribed medication and a wrist splint, which improved claimant's symptoms.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's left thumb/wrist condition requiring treatment by Drs. MacDonald and Nye in May and June 1992 was different from her left thumb/wrist condition requiring treatment by Dr. Layman in July and August 1992. Reasoning that a hearing request concerning the condition in July/August 1992 would be premature, the Referee limited his review to the compensability of the calcific tendinitis diagnosed by Dr. Nye in May/June 1992, and on the merits, concluded that the calcific tendinitis is not compensable. We disagree with the Referee's analysis and conclusion.

We find that claimant's condition requiring treatment in May/June 1992 was the same condition requiring treatment in July/August 1992. Although claimant's left thumb/wrist pain had subsided when

Dr. Nye removed her cast in May 1992, claimant testified that the same pain recurred and worsened when she resumed her work duties. (Tr. 12-13). She then sought treatment with Dr. Layman. Claimant's testimony is uncontroverted. Hence, we are persuaded that claimant had one left thumb/wrist condition which Dr. Nye and Dr. Layman diagnosed differently.

We are also persuaded that Dr. Layman's diagnosis of wrist capsulitis/tendinitis with thumb osteoarthritis is a more reliable description of claimant's condition requiring treatment, than Dr. Nye's diagnosis of calcific tendinitis. Dr. Layman's diagnosis was supported by the x-ray report in May 1992. (Ex. 15-1). Further, Dr. Layman had the opportunity to review Dr. Nye's chart notes, whereas there is no indication that Dr. Nye reviewed Dr. Layman's notes. Dr. Layman also had the benefit of bone scan results which Dr. Nye did not review. (Ex. 15-4). Indeed, in his deposition, Dr. Nye expressed uncertainty about the kind of disorder claimant had. (Ex. 19-5). He ordered a rheumatological consultation and blood studies, but they were not performed. (Id.)

Although SAIF's denial specifically refers to the diagnosis of "calcific tendinitis," we find that claimant's claim was not so limited. Claimant sought compensation for her left thumb/wrist pain. SAIF effectively denied claimant's need for treatment in May/June 1992. Inasmuch as we have found that the condition causing that need for treatment is the same condition Dr. Layman treated in July/August 1992, we find that SAIF effectively denied the condition ultimately diagnosed as wrist capsulitis/tendinitis with thumb osteoarthritis. Claimant's hearing request, and the hearing transcript itself, persuades us that claimant was litigating the compensability of her pain condition (see Tr. 2), not a particular diagnosis. Accordingly, we are persuaded that the compensability of claimant's thumb/wrist pain condition is ripe for adjudication and was properly raised before the Referee.

SAIF cites Tattoo v. Barrett Business Services, 118 Or App 348 (1993), for the proposition that its denial must be interpreted as a denial of "calcific tendinitis" only. We disagree. The court in Tattoo held that, in determining whether a denial impermissibly covers future treatment, as well as current treatment, a carrier is bound by the express terms of its denial. Id. at 351-52. Because this case does not involve an allegedly prospective denial, the holding in Tattoo is inapposite.

On the merits of the denial, we are most persuaded by the opinion of Dr. Layman because it was based on the most thorough medical record. He opined that claimant's work activity was the major contributing cause of claimant's current condition. (Ex. 17). Accordingly, we find that claimant has established a compensable occupational disease claim for her left thumb/wrist condition. See ORS 656.802(1)(c), (2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494, 502, rev den 312 Or 150 (1991).

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 $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 claimant's appellate briefs, claimant's counsel's 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 30, 1993, as reconsidered May 26, 1993, is reversed. The SAIF Corporation's denial of claimant's left thumb/wrist condition is set aside, and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by SAIF.

In the Matter of the Compensation of
ROSALIE S. DREWS, Claimant
WCB Case Nos. 90-05597 & 90-15186
ORDER ON REMAND
Rasmussen & Henry, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney
David O. Horne, Defense Attorney

This matter is before the Board on remand from the Supreme Court. SAIF v. Drews, 318 Or 1 (1993). The Court reversed the Court of Appeals decision, 117 Or App 596 (1993), which had affirmed the Board's order in Rosalie S. Drews, 44 Van Natta 36 (1992), holding that the SAIF Corporation was responsible for claimant's low back condition under ORS 656.308(1). The Court remanded to the Board for further proceedings in light of its holding that ORS 656.005(7)(a)(B) applied to the shifting of responsibility among employers under ORS 656.308(1), whether or not the "preexisting condition" was compensable.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted low back sprain with Wausau Insurance Companies. In May 1989, claimant received a total of 20 percent permanent disability. In December 1989, claimant tripped and fell over a desk drawer while working for the SAIF Corporation's insured, and experienced increased low back symptoms. The Referee, finding that the December 1989 event was not the major contributing cause of claimant's disability and need for treatment, concluded that claimant did not sustain a "new compensable injury" under ORS 656.308(1) and, thus, responsibility remained with Wausau.

The Board reversed, rejecting SAIF's assertion that ORS 656.005(7)(a)(B) applied in determining responsibility. Instead, the Board concluded that, because the record showed that the 1989 incident was a material contributing cause of disability or the need for treatment, responsibility shifted to SAIF. Rosalie S. Drews, supra.

The Court of Appeals agreed with the Board's analysis that "the major contributing cause" limitation for determining a "compensable injury" under ORS 656.005(7)(a)(B) did not apply to responsibility determinations under ORS 656.308(1), finding that the statutory provision applied only after an initial determination was made that the injury was compensable. Specifically, the court determined that the "preexisting disease or condition" to which (7)(a)(B) referred must be noncompensable. Since claimant's earlier low back injury for the aggravation carrier was compensable, the Court of Appeals held that (7)(a)(B) was not applicable. Furthermore, applying ORS 656.308(1), the court affirmed the Board's reasoning that the aggravation carrier successfully proved that claimant's subsequent low back injury was "a material contributing cause" of claimant's disability or need for treatment and, therefore, responsibility for claimant's low back condition shifted to SAIF, the "new injury" carrier.

The Supreme Court reversed the Court of Appeals' decision and the Board's order. Concluding that it was unclear from the text or context of the 1990 amendments whether the legislature intended the "major contributing cause" limitation of (7)(a)(B) to apply to responsibility determinations under ORS 656.308(1), the Court turned to the legislative history. After reviewing the history, the Court determined that the 1990 amendments were designed to make it more difficult to shift responsibility to a subsequent employer, which supported the theory that "the major contributing cause" limitation in (7)(a)(B) was meant to apply to responsibility determinations. Moreover, in light of specific statements in the legislative history pertaining to responsibility determinations, the Court was persuaded that (7)(a)(B) was meant to apply in the context of shifting responsibility to a subsequent employer.

Interpreting ORS 656.005(7)(a), the Court reached the following conclusions. "Compensable injury" encompasses an application of the limitation criteria found in ORS 656.005(7)(a)(A)(B). In other words, if the accidental injury described in paragraph (a) combines with a preexisting condition, to be compensable the injury must be "the major contributing cause of the disability or need for treatment" under subparagraph (B). The Court reasoned that such a determination is made regardless of whether the preexisting condition was compensable.

Turning to ORS 656.308(1), the Court concluded that if the accidental injury was found not to be "the major contributing cause" under ORS 656.005(7)(a)(B), claimant would not have sustained a "new compensable injury involving the same condition" as described in ORS 656.308(1). Consequently, the Court determined that the first employer would remain responsible. Conversely, if the accidental injury was "the major contributing cause," the Court held that responsibility would shift to the subsequent employer because claimant would have sustained a "new compensable injury involving the same condition."

Since the Court of Appeals and Board decisions had not applied ORS 656.005(7)(a)(B) to their responsibility determination, the Supreme Court reversed and remanded for further proceedings. We now proceed with our review in light of the Court's opinion.

In February 1990, after her December 1989 trip and fall at SAIF's insured, claimant underwent an MRI. The findings were interpreted as showing a "mild posterior central disc bulging at L5-S1, slightly more prominent than on a previous study of 9 September 1986" and a "central posterior annular bulging at L4-5 which also appears slightly more prominent than on the previous study." (Ex. 39A).

In March 1990, Dr. Woolpert, orthopedic surgeon, conducted an examination at SAIF's request. Dr. Woolpert diagnosed "degenerative disc disease of the lumbar spine." (Ex. 51-4). Dr. Woolpert also noted that the slightly increased bulging noted by the MRI report was "consistent with worsening that would be anticipated with the passage of time in regard to a person with degenerative disc disease. I would not feel that the worsening as described on the report represents a reaction to a previous injury." (Id. at 4-5). Dr. Woolpert concluded that claimant "had a symptomatic exacerbation of her pre-existing status." (Id. at 5).

Dr. Nagel, claimant's treating orthopedic surgeon, reported that claimant developed more pain following the December 1989 incident and that the "diagnosis remains the same." (Ex. 54-1). Dr. Nagel further stated that claimant's "current etiology of her current back condition is the bulging disc at L4-L5 and L5-S1 of her lumbar spine." (Id). Dr. Nagel found that, because the MRI showed a worsened condition, claimant's "current symptoms [were] due to the more recent injury." (Id. at 2). However, Dr. Nagel also stated that he was at a "disadvantage" since he did not see claimant until February 21, 1990. (Id).

Based on the opinions of Drs. Woolpert and Nagel, we find that claimant's preexisting compensable condition with Wausau combined with the December 1989 event at SAIF's insured, and that the resultant condition caused the need for treatment. Therefore, Wausau remains responsible unless the December 1989 incident at SAIF's insured was the major contributing cause of claimant's disability and need for treatment. SAIF v. Drews, supra.

Absent persuasive reasons to the contrary, we give greater weight to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Although Dr. Nagel is the treating physician, we find persuasive reasons not to defer to his opinion.

First, although attributing claimant's increased pain to the December 1989 fall, Dr. Nagel concluded that claimant's "diagnosis remains the same." We do not consider such an observation as supportive evidence for a conclusion that the December 1989 fall was the major contributing cause of claimant's resultant disability. Second, Dr. Nagel's only basis for finding that claimant's symptoms were due to the December 1989 fall was the slightly increased bulging shown on the February 1990 MRI. However, the study was compared to a previous one in September 1986, and the record contains no evidence regarding the size of the bulge during the interval between September 1986 and February 1990. In view of the long period of time between the two studies, we are not convinced that the slight change noted in the more recent findings is attributable to the December 1989 event.

Finally, Dr. Nagel acknowledged that he was at a "disadvantage" due to the time lapse between claimant's December 1989 fall and the February 1990 examination. We view this statement as evidence that Dr. Nagel considered the delay between the fall and his examination as having reduced his ability to determine causation.

The remaining opinion from Dr. Woolpert provided that the slight worsening noted on the MRI was due to aging and that claimant experienced only a symptomatic worsening of her preexisting condition. We understand his opinion as indicating that the December 1989 incident was not the major contributing cause of claimant's need for treatment.

Therefore, having found that Dr. Nagel's opinion is not persuasive and because Dr. Woolpert's opinion does not show that the December 1989 fall was the major contributing cause of claimant's need for treatment, we conclude that responsibility remains with Wausau.

Finally, we note that claimant moves for remand to the Hearings Division because the Supreme Court's decision "moved the goal post" in responsibility law. In particular, claimant asserts that the presentation of her case at hearing "was based on the longstanding caselaw, which held that a showing of material cause was sufficient to shift responsibility" and that subsequent litigation interpreted ORS 656.308 as applying the major contributing cause standard. SAIF opposes the motion, asserting that, because the 1990 legislative amendments were in effect at the time of the hearing, the "goal post" had already been moved as of the date of the hearing.

We agree with SAIF. We may remand a case to the Referee if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a "compelling reason" must be shown for remanding. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

We acknowledge that, at the time of the hearing, there was no caselaw interpreting ORS 656.308(1). Nevertheless, every party is presented with such circumstances when litigating a claim under a new statutory enactment or amendment. More importantly, although the medical evidence regarding claimant's current condition and its relationship to her employments may be sparse, we consider the record to be properly, completely and sufficiently developed to resolve the responsibility dispute under the Court's interpretation of ORS 656.308(1). Therefore, we find that there is no compelling reason to remand and we deny the motion.

Accordingly, on remand, the Referee's order dated December 21, 1990 is affirmed. We republish that portion of the Board's January 10, 1992 order which held that claimant's counsel was entitled to a $700 attorney fee for services on Board review. However, we conclude that the attorney fee award shall be paid by Wausau.

IT IS SO ORDERED.

In the Matter of the Compensation of
PENNY L. HAMRICK, Claimant
WCB Case Nos. 92-13017 & 92-04669
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys
Neil W. Jones, Defense Attorney

Fireman's Fund Insurance Company requests reconsideration of our January 5, 1994 Order on Review that affirmed a referee's order which set aside Fireman's denial of claimant's occupational disease claim for a right elbow condition and upheld Safeco Insurance Company's denial of claimant's claim for the same condition. Disagreeing with the "responsibility/disclaimer" portion of our order, Fireman's contends that, due to Safeco's failure to properly disclaim responsibility, Safeco is precluded from arguing that claimant's employment exposure with Fireman's insured caused her disability or need for treatment.

In order to consider Fireman's contentions, we abated our January 5, 1994 Order on Review. Having received the parties' responses, we proceed with our reconsideration.

On reconsideration, Fireman's argues that Safeco was required to comply with ORS 656.308(2), which provides that a carrier must provide written notification of its intent to disclaim responsibility for a claim on the basis that the worker's injury resulted from exposure with another employer. Safeco does not disagree with Fireman's contention that it failed to comply with the disclaimer statute. Rather, Safeco argues that because claimant filed a claim against Fireman's, she may establish her claim notwithstanding Safeco's failure to properly disclaim responsibility. We agree.

In Jon F. Wilson, 45 Van Natta 2362 (1993), we held that failure to follow the requirements of ORS 656.308(2) precludes a carrier from arguing that another employment exposure caused a claimant's need for medical services. See Byron E. Bayer, 44 Van Natta 1686, 1687 (1992). However, we further concluded that the claimant's failure to file a claim against a carrier within 60 days of the second carrier's disclaimer did not preclude the claimant from asserting compensability against the first carrier. We concluded that ORS 656.308(2) addresses responsibility for a claim and does not pertain to compensability. Therefore, we held that the claimant in Wilson was not precluded from filing an occupational disease claim against the first carrier, pursuant to the filing requirements set forth in ORS 656.807(1). Wilson, supra.

Here, claimant timely filed an occupational disease claim with Fireman's in April 1992. ORS 656.807(1). Accordingly, we conclude that claimant may proceed to prove the compensability of an occupational disease against Fireman's. Safeco's acknowledged failure to comply with the disclaimer notice of ORS 656.308(2) precludes Safeco from attempting to shift responsibility for the claim to Fireman's. Nevertheless, Safeco's violation does not preclude claimant from pursuing the compensability of her timely filed occupational disease claim against Fireman's.

Turning to the merits, we agree with the Referee's conclusion that Dr. Lawton, claimant's treating physician, has provided the most persuasive opinion regarding causation of claimant's condition. Claimant's work with Fireman's insured included repetitive vacuuming with a heavy machine that was difficult to push. Claimant also performed heavy lifting at her job, and her work activities consistently involved use of her right elbow. Furthermore, after reviewing the record, we conclude that Dr. Lawton's opinion establishes that claimant's work activity with Fireman's insured is the major cause of the worsening of her right elbow condition. We, therefore, find that claimant has established a compensable right elbow claim against Fireman's.

Claimant is entitled to an additional attorney fee for services on reconsideration. ORS 656.382(2); Rene G. Gonzalez, 45 Van Natta 499 (1993). 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 reconsideration is $500, to be paid by Fireman's. 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, on reconsideration, as supplemented herein, we adhere to and republish our January 5, 1994 order. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK S. LILLIBRIDGE, Claimant
WCB Case No. 93-01844
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of those portions of Referee Peterson's order which: (1) reduced claimant's unscheduled permanent disability award from 26 percent (83.2 degrees), as granted by an Order on Reconsideration, to 23 percent (73.6 degrees); and (2) assessed a 25 percent penalty under ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability and claimant's entitlement to a penalty under ORS 656.268(4)(g). We reverse in part and modify in part.

FINDINGS OF FACT

Claimant sustained a compensable acute cervical strain, left shoulder contusion, and chest-wall contusion. His job at the time of injury was dump truck driver (DOT # 902.683-010). Claimant was released to regular work without restrictions on June 2, 1992 by his attending physician, Dr. Dunn, and was considered medically stationary on that date.

The claim was closed by Notice of Closure on June 26, 1992, with no award of permanent disability. An Order on Reconsideration of February 12, 1993 awarded claimant 26 percent unscheduled permanent disability. The Department based its award on an impairment value of 18 and a value of 8 for claimant's vocational factors, including a value of 2 for claimant's adaptability factor. The Department did not assess a penalty under ORS 656.268(4)(g), even though claimant's permanent disability award was increased by more than 25 percent and claimant was determined to be more than 20 percent disabled.

CONCLUSIONS OF LAW AND OPINION

The Referee reduced claimant's unscheduled award, finding that claimant's impairment value should be 15 rather than 18. Although claimant was released to regular work, the Referee found that claimant had in fact returned to modified employment. Accordingly, the Referee adopted the adaptability factor assigned by the Department, as well as the values assigned to the other vocational factors, for a total of 8. Adding this sum to the impairment value of 15, the Referee arrived at a disability award of 23 percent.

SAIF's sole contention is that the Referee erred in adopting the adaptability value of 2 that was assigned to claimant in the February 12, 1993 Order on Reconsideration. The Department had based this value on the difference between the highest prior strength required in jobs claimant performed in the ten years preceding the time of determination (medium) and a maximum residual capacity at the time of determination (light-medium). SAIF asserts that claimant's residual functional capacity remains at the level of medium strength, thereby requiring an adaptability factor of 1 under the temporary rules effective June 17, 1993. See WCD Admin. Order 93-052.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2); See Michelle Cadigan, 46 Van Natta 307 (1994).

Claimant became medically stationary on June 2, 1992, and his claim was closed by Notice of Closure on June 26, 1992. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the Notice of Closure. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 6-1992. Thus, the issue is whether claimant is entitled to a value for adaptability under the relevant standards.

The pertinent administrative rule is OAR 436-35-310(2) (WCD Admin. Order 6-1992), which provides that, for workers that have a release to regular work or have either returned to or have the residual functional capacity to perform regular work, the value for the factor of adaptability is zero. Here, claimant's at-injury job was as a dump truck driver. He was released by his attending physician, Dr. Dunn, to his regular work with absolutely no restrictions. (Ex. 14). Although claimant testified that he returned to driving a transfer vehicle rather than a dump truck, the DOT draws no distinction between the physical capacity required for the performance of each kind kind of driving. Further, there was no evidence that the physical demands of driving a transfer vehicle are less than those of driving a dump truck. We are mindful that the medical arbiter, Dr. Fitzsimmons, opined that claimant was unable to repetitively use his left arm and shoulder. (Ex. 23). However, Dr. Fitzsimmons did not restrict claimant's return to work.

Accordingly, since claimant was released to return to his regular truck driving duties without restriction, we conclude that his adaptability value is zero under the applicable standards. Therefore, we disagree with the Referee's evaluation of the extent of claimant's unscheduled permanent disability.

Because the adaptability factor is a multiplier, claimant is not entitled to any value for the vocational factors of age, education and adaptability. Since no party challenges the Referee's impairment value of 15, claimant's unscheduled permanent disability is 15 percent. We modify claimant's award accordingly.

Finally, the Referee assessed a 25 percent penalty under ORS 656.268(4)(g). The Referee reasoned that, with the reduction of claimant's unscheduled permanent disability from 26 to 23 percent, claimant still received an increase of more than 25 percent disability and was at least 20 percent disabled.

We have reduced the Department's permanent disability award below the level for which the claim qualifies for a penalty under ORS 656.268(4)(g). Therefore, even assuming that we were authorized to make such an assessment, claimant would not be entitled to a penalty. See Vena K. Mast, 46 Van Natta 34 (1994).

ORDER

The Referee's order dated May 25, 1993 is reversed in part and modified in part. That portion which assessed a penalty under ORS 656.268(4)(g) is reversed. In lieu of the Referee's award, claimant's unscheduled permanent disability award is reduced from 26 percent (83.2 degrees), as granted by the Order on Reconsideration, to 15 percent (48 degrees).

March 10, 1994 Cite as 46 Van Natta 413 (1994)

In the Matter of the Compensation of
WILLIAM M. PINARD, Claimant
WCB Case No. 93-04223
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Carol Smith (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Galton's order that dismissed claimant's hearing request for lack of jurisdiction over claimant's dispute with the SAIF Corporation regarding the hourly rate and the amount of time for which SAIF paid claimant's wife for providing home health care services. On review, the issues are jurisdiction and medical services. We remand.

FINDINGS OF FACT

On September 9, 1992, claimant was compensably injured in a motor vehicle accident involving logging equipment. Claimant sustained multiple injuries in this accident and underwent surgical amputation of his right leg on September 9, 1992. (Ex. 1). Claimant was discharged from the hospital on November 2, 1992. (Ex. 5).

Dr. Valleroy, claimant's treating physician, recommended home health care services following claimant's release from the hospital. (Ex. 2). From claimant's discharge on November 2, 1992 to December 15, 1992, Dr. Valleroy recommended that claimant receive assistance with bathing, ambulation (supervision on stairs), dressing changes, and chopping and carrying wood into his wood heated home. (Exs. 2, 5, 7, 9). From December 15, 1992 through January 11, 1993, Dr. Valleroy recommended that claimant receive assistance with dressing changes, chopping and carrying wood into his home, and possibly bathing. (Exs. 2, 7, 9). As of June 4, 1993, claimant continued to require dressing changes. (Ex. 7).

Ms. Mintun, SAIF's Nurse Consultant, estimated the time required to provide assistance to claimant for the activities of bathing, stair climbing, and dressing changes. SAIF paid claimant's wife for this estimated time at the minimum wage, $4.75 per hour. (Exs. 3, 5). SAIF did not estimate or pay for any time spent chopping or carrying wood to heat claimant's home. Id.

On April 7, 1993, claimant requested a hearing, raising the issues of "de facto" denial of medical services, and penalties and attorney fees regarding the alleged unreasonable denial. A hearing was set for June 30, 1993. SAIF filed a motion to dismiss the hearing for lack of jurisdiction. At hearing, the Referee granted SAIF's motion and issued an order dismissing claimant's hearing request.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the issues claimant raised regarding the hourly rate and the amount of time for which SAIF paid his wife for performing home health care services were issues within the Director's exclusive jurisdiction. Therefore, the Referee concluded that the Hearings Division lacked jurisdiction over this medical services dispute. In so holding, the Referee relied on Mark L. Hadley, 44 Van Natta 690 (1992) and Pamela J. Panek, 44 Van Natta 1625 (1992). These decisions, in turn, relied on our decision in Stanley Meyers, 43 Van Natta 2643 (1991).

The court has reversed our decision in Meyers. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). The court held that the 1990 amendments to ORS 656.327(1) do not require the parties or the Director to invoke the Director review process. The court reasoned that the 1990 amendments left untouched the parties' discretion to request Director review or to bring the dispute to the Board for resolution. Relying on ORS 656.327(1), the court determined that if a party or the Director "wishes review of the treatment by the director," and gives notice, the statute provides the procedure for a proceeding, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. Without a "wish" for Director review and a notice filed with the Director, the court further concluded that there is no "proceeding" before the Director. Reasoning that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create the jurisdiction occur, the court held that those conditions did not occur in Stanley Meyers. Accordingly, the court found that the medical treatment dispute remained within the Board's jurisdiction. Relying on Meyers, the court has also reversed our decisions in Hadley and Panek. Hadley v. Silverton Forest Products, 123 Or App 629 (1993); Panek v. Oregon Health Sciences University, 123 Or App 623 (1991).

Here, there is no evidence that either of the parties requested Director review. Instead, claimant filed a request for hearing, raising the issue of "de facto" denial of medical services. At hearing, claimant's attorney clarified the issues as being a dispute regarding the hourly rate and amount of time paid to claimant's wife for her provision of home health care services to claimant. (Tr. 2). Under such circumstances, we conclude that the Director did not have exclusive jurisdiction over this matter and that the Referee was authorized to consider the dispute. See Meyers v. Darigold, Inc., supra; Robert P. Holloway, Sr., 45 Van Natta 2036 (1993).

We may remand to the Referee if we determine that the record has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295(5). Although several exhibits were admitted into the record, no testimony was taken, given the Referee's determination that he did not have jurisdiction over the medical services issue.

Under these circumstances, we find that the record has been incompletely developed and we find a compelling reason to remand. ORS 656.295(5); see Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Accordingly, we remand to Referee Galton for further proceedings consistent with this order. The Referee may proceed in any manner that will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated June 30, 1993 is vacated. This matter is remanded to Referee Galton for further proceedings consistent with this order.

In the Matter of the Compensation of
PAMELA A. BURT, Claimant
WCB Case No. 93-00667
ORDER ON REVIEW
S. David Eves, Claimant Attorney
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion", with the exception of the reasoning regarding causation, and with the following supplementation.

To prevail on her occupational disease claim, claimant must prove that her employment conditions were the major contributing cause of her CTS. ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145 (1983); Enid S. Crowe, 45 Van Natta 1718 (1993).

Claimant relies on the opinions of her treating physician, Dr. Ellison. Although we ordinarily defer to the opinion of the treating physician, we find persuasive reasons not to do so here. Weiland v. SAIF, 65 Or App 810 (1983).

In his initial evaluation of claimant, Dr. Ellison recorded that claimant began to experience swelling and aching in her right hand following her July 1992 work-related accident. (Ex. 5-1). He recorded claimant's past history as "[u]nremarkable." (Id). After conducting a physical examination, Dr. Ellison concluded that claimant had right CTS related to her use of a power hose at work. (Id. at 5). Thereafter, Dr. Ellison diagnosed left CTS. (Ex. 6-2).

In his final opinion, Dr. Ellison stated that it was his "sense" that, to a reasonable medical probability, claimant's symptoms were "associated with her employment activities" because claimant noted the onset of CTS symptoms after her July 1992 accident and because she had been using a power hose repetitively. (Ex. 16-1).

We find Dr. Ellison's opinions flawed for the following reasons. First, there is no indication that he considered other possible causes of claimant's CTS. See, e.g., Somers v. SAIF, 77 Or App 259 (1986); Luella M. Best, 45 Van Natta 1638 (1993). At hearing, claimant testified that she had worked for another employer performing work similar to that which she performed for this employer. (Tr. 14-15). She used a power hose for one year for the former employer. (Tr. 16). Claimant also testified that she did some heavy lifting at home that brought on her CTS symptoms. (Tr. 24). Because there is no indication that Dr. Ellison was aware of those activities, he was precluded from considering whether they could have contributed to claimant's CTS. See Pamela Wold, 43 Van Natta 362 (1991).

Second, Dr. Ellison failed to discuss, in any detail, the mechanics of claimant's work activities, including her use of a power hose. In the absence of such detail, we discount Dr. Ellison's opinions. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Lastly, if one overlooks the foregoing defects in Dr. Ellison's opinions, all that is left is the temporal relationship between claimant's onset of symptoms and her work for the employer. However, because such a relationship will not, by itself, satisfy claimant's burden of proof, see ORS 656.266; Ruben G. Rothe, 45 Van Natta 369 (1993), we afford Dr. Ellison's opinions minimal probative weight.

For these reasons, we conclude that Dr. Ellison's opinion that claimant's CTS probably was "associated with" her work duties for the employer is not sufficient to meet her burden under the major contributing cause standard. ORS 656.802(2). Accordingly, we affirm the Referee's conclusion that claimant's CTS is not compensable.

ORDER

The Referee's order dated June 10, 1993 is affirmed.

March 11, 1994 Cite as 46 Van Natta 416 (1994)

In the Matter of the Compensation of
JEROME D'ARCY, Claimant
WCB Case No. 92-15241
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Neal's order that: (1) reduced his award of unscheduled permanent disability for a low back and neck injury from 17 percent (54.4 degrees), as awarded by Order on Reconsideration, to 5 percent (16 degrees); and (2) admitted certain testimony and a videotape. In its brief, the self-insured employer contends that the Referee erred in declining to admit certain medical evidence. On review, the issues are evidence and extent of unscheduled permanent disability.

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

Claimant first contends that the employer is precluded from challenging the impairment findings used to close his claim because it did not specifically challenge those findings at the reconsideration process. Assuming, arguendo, that claimant's contention is correct, the employer would still be allowed to challenge, at hearing, the impairment findings used to close the claim.

Subsequent to the Referee's order, we issued our decision in Darlene K. Bentley, 45 Van Natta 1719 (1993). In Bentley, we disavowed our prior decision in Raymond L. Mackey, 45 Van Natta 776 (1993), which held that a party is barred from raising at hearing an issue stemming from a notice of closure or determination order that was not first raised on reconsideration before the Department. Relying on Safeway Stores, Inc. v. Smith, supra, we concluded that the clear language of ORS 656.283(7) allowed a party to establish at hearing that the standards were incorrectly applied in the reconsideration proceeding without limitation. Id. Thus, a party may raise for the first time at hearing a challenge to one or more of the factors used by the Department in rating permanent disability. Id. Accordingly, the employer was not precluded from challenging, for the first time at hearing, the impairment findings used to rate claimant's disability.

Claimant next contends that the Referee erred in admitting a videotape and allowing Mr. Flint, a physical therapist, to testify. In addition, the employer argues that the Referee erred in excluding Exhibits 57 through 65. The disputed exhibits are "post-reconsideration order" medical reports from the attending physician, consulting physicians, and the medical arbiter. Both claimant's and the employer's objections focus mainly on the admissibility of the evidence pursuant to ORS 656.268(7).

Since a medical arbiter was appointed (Dr. Gritzka), ORS 656.268(7) prohibits the admission of medical evidence concerning claimant's impairment that was developed after the medical arbiter's report, but not the medical arbiter's report itself. Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). Thus, with the exception of Exhibits 58 and 63, which are from Dr. Gritzka, the medical arbiter, none of the other "post-medical arbiter" medical evidence would appear to be admissible for evaluating claimant's permanent impairment. Inasmuch as Exhibits 58 and 63 are supplemental reports from the medical arbiter, those reports are admissible. See Lorenzo Orozco-Santoya, 46 Van Natta 150 (1994).

In addition, to the extent that Mr. Flint's testimony concerned the extent of claimant's permanent impairment, it could not be considered, even to impeach the opinion of the treating physician or the medical arbiter. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994).

Nevertheless, we need not resolve these questions because the exhibits, even if considered, would not affect the outcome of this case.

In reaching her conclusion regarding the extent of claimant's permanent disability, the Referee relied on the opinion of Dr. Gritzka, the medical arbiter. We agree with the Referee's conclusion that Dr. Gritzka's opinion is the most persuasive evidence concerning the extent of claimant's permanent disability.

Moreover, because we rely on Dr. Gritzka's opinion, we agree that claimant is not entitled to additional disability as a result of lumbar impairment. (Ex. 55). We reach this conclusion because Dr. Gritzka reported that the lumbar range of motion findings were not valid.

Finally, claimant objects to the admission of Exhibit 66, the videotape, on the basis that it was not timely provided to claimant. We agree with the Referee that it did not have to be provided to claimant because it was impeachment evidence. OAR 438-07-017 provides that evidence "reasonably believed relevant and material only for purposes of impeachment," may be withheld. Because the language of that rule is permissive, the Referee had the discretion to decide whether or not to admit impeachment evidence offered under that rule. See Patrick J. Valenzuela, 45 Van Natta 1116 (1993). Here, we find no abuse of discretion by the Referee, particularly since, as noted above, the Referee relied (as do we) on the opinion of Dr. Gritzka (who did not view the videotape) to determine the extent of claimant's permanent disability.

ORDER

The Referee's order dated March 25, 1993, as reconsidered April 12, 1993, is affirmed.

March 11, 1994 Cite as 46 Van Natta 417 (1994)

In the Matter of the Compensation of
BILLIE I. ENSLEY, Claimant
WCB Case No. 93-03765
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Spangler's order which set aside its denial of claimant's current cervical condition. On review, the issue is compensability.

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

In lieu of the Referee's finding of fact that claimant was examined by Dr. Anderson the same day she developed neck and right shoulder pain in May 1992, we find that she was examined by Dr. Anderson in the week following this incident. (Exs. 38-1, 65-5 to 65-6).

After our review of the record, we agree with the Referee's determination that claimant's physical therapy regimen, prescribed for her compensable low back injury of April 1991, was the major contributing cause of her current neck condition. Therefore, the current neck condition is compensable. See George Hames, Jr., 45 Van Natta 2426 (1993) (claimant proved that physical therapy for compensable condition was major contributing cause of consequential condition).

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 July 28, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
RUTH E. GRIFFIN, Claimant
WCB Case No. 93-01985
ORDER ON REVIEW
Daniel Spencer, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Nichols' order which: (1) held that claimant could not raise an issue of premature claim closure because she did not first raise that issue in her request for reconsideration; and (2) affirmed an Order on Reconsideration that awarded 2 percent (3 degrees) scheduled permanent disability for loss of use or function of the left leg (knee). On review, the issues are premature closure and, alternatively, extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant requested reconsideration of a July 29, 1992 Notice of Closure which awarded temporary disability and 2 percent scheduled permanent disability.

On the request for reconsideration form, claimant checked boxes requesting reconsideration on the issues of temporary disability benefits, impairment findings, and scheduled permanent disability. Claimant did not check boxes on the form which provided for the issues of medically stationary date and premature claim closure.

The Order on Reconsideration modified the temporary disability award and affirmed the Notice of Closure in all other respects. Claimant requested a hearing, raising issues of premature closure and, alternatively, extent of permanent disability.

ULTIMATE FINDINGS OF FACT

On July 29, 1992 (when the Notice of Closure issued closing the claim), further material improvement of claimant's left knee could reasonably be expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

Premature closure

Relying on Raymond L. Mackey, 45 Van Natta 776 (1993), the Referee concluded that, because claimant did not raise the issue of premature closure at the time of the reconsideration proceeding, claimant could not raise the issue for the first time at hearing. We disagree with that conclusion.

Subsequent to the Referee's order, the court issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In that case, the court held that the claimant's adaptability, for purposes of rating permanent disability, must be determined on the basis or work status as of the date of the reconsideration order, rather than the date of the prior determination order. The Smith court determined that, pursuant to ORS 656.268(5), a referee may consider evidence at hearing that was not submitted on reconsideration.

Given the court's determination that the reconsideration and hearing levels constitute two distinct proceedings, we subsequently concluded that Mackey should no longer be given effect. See Darlene K. Bentley, 45 Van Natta 1719 (1993). Consequently, we concluded that the parties may raise extent of permanent disability issues at hearing, regardless of whether those issues were specifically raised at the reconsideration proceeding. Bentley, supra. We have since extended that analysis to temporary disability issues. See Hugh D. Brown (45 Van Natta 2188 (1993)(Bentley cited where the insurer was allowed to challenge a claimant's temporary disability award, even though the insurer had not specifically requested reconsideration on the issue of temporary disability).

Consequently, in light of our decision that Mackey should no longer be given effect, we reexamine our decision in Chester L. Schulze, 44 Van Natta 1493 (1992). In Schulze, we held that a claimant who had not requested reconsideration on an issue of premature closure could not raise that issue for the first time at hearing. In support of our conclusion, we cited to ORS 656.268(5), and to prior Board cases which relied upon a general "exhaustion of administrative remedies" approach. However, that reasoning also comprised the underpinnings of the Mackey case, which we have determined should be given no effect.

Accordingly, consistent with the Bentley case and with our decision to disavow Mackey, supra, we conclude that claimant may raise an issue of premature closure at hearing that was not specifically raised on reconsideration. Furthermore, to the extent that our decision in this matter conflicts with our holding in Chester L. Schulze, supra, we disavow our prior decision.

We conclude that our decision in this matter is also consistent with the rationale expressed in Bentley regarding the efficiency of the system. In Bentley, supra, we found that the implementation of the reconsideration process itself and its objective to take appropriate action are consistent with the legislative goal of reducing litigation. Specifically, we find that the present case illustrates why our approach in Bentley is consistent with the expressed goal of reducing litigation.

Here, Dr. Smith, the medical arbiter, raised the issue of premature closure by finding that claimant was not medically stationary at the time of closure. Accordingly, under the facts of the case, claimant may either have an aggravation claim or her claim may have been prematurely closed. As a result of our decision to address the premature closure issue (notwithstanding claimant's failure to "check" that box when requesting reconsideration), the issue may be resolved without claimant having to proceed to a second hearing on an aggravation theory. Accordingly, for this additional reason supporting a goal of reduced litigation, we conclude that Bentley should be followed in the present case.

Finally, although the Smith court addressed an extent of disability matter, the court cited to ORS 656.283(7) as support for its conclusion that the referee may consider evidence that could not have been submitted to the Department on reconsideration. Smith, supra. ORS 656.283(7) is not limited to extent issues, however, as the statute further provides that if a referee finds that a claim has been prematurely closed, the referee shall issue an order rescinding the determination order or notice of closure. ORS 656.283(7). Consequently, we find that, because the statute specifically permits a referee to make findings regarding premature closure, our decision in this case is consistent with the Smith court's holding that the referee may consider evidence not submitted at the time of reconsideration.

As we have determined that claimant could properly raise the issue of premature closure at hearing, we now turn to the merits of her claim. We conclude that the claim was prematurely closed.

In order to establish that the July 29, 1992 Notice of Closure prematurely closed her claim, claimant must demonstrate that she was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). In determining whether claimant has met her burden of proof, we examine medical evidence available at the time of closure, as well as evidence thereafter, except that which pertains to changes in claimant's condition subsequent to closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, rev den 303 Or 590 (1987).

Dr. Carroll, M.D., performed claimant's prior noncompensable left knee surgery in 1990, and saw claimant on referral following the compensable March 1992 incident when claimant fell at work and fractured her left patella. On June 19, 1992, Dr. Carroll performed a closing examination and found that claimant's left knee range of motion was 0-135, as compared to 0-140 for the right knee. Dr. Carroll reported that claimant was having increased discomfort, with pain and puffiness of her knee. He opined, however, that she had recovered well from her fracture and he did not recommend further "procedures," unless claimant was unable to continue her work.

On January 9, 1993, claimant was examined by a medical arbiter, Dr. Smith, M.D. Dr. Smith reviewed Dr. Carroll's closing exam and performed his own examination. Dr. Smith noted claimant's report that she had progressively lost range of motion since the prior summer (1992), and he measured

her left knee range of motion at 5-120. Dr. Smith also reported that claimant was unable to use her left knee repetitively, and he further stated that, when compared to Dr. Carroll's exam, it was doubtful that claimant's condition was medically stationary.

On February 2, 1993, Dr. Smith clarified his earlier report and stated that, in retrospect, claimant was not medically stationary at the time of her closing exam on June 19, 1992. Dr. Smith reported that claimant's lost range of motion and her inability to use her left knee repetitively were due to the compensable injury in March 1992.

We conclude that Dr. Smith's opinion is consistent with claimant's testimony, insofar as claimant testified that she had lost more range of motion since June 1992. Claimant also testified that, following Dr. Carroll's examination in June 1992, her knee had become stiffer and harder to bend.

Because Dr. Smith examined claimant, took her history and reviewed her prior records, we find that he is competent to assess her condition at the time of the July 29, 1992 Notice of Closure. Furthermore, we find Dr. Smith's complete and well-reasoned opinion to be persuasive, as it is supported by his range of motion findings and claimant's testimony. See Somers v. SAIF, 77 Or App 259 (1986).

Finally, we do not consider Dr. Smith's observations to represent an inappropriate appraisal of any change in claimant's condition since claim closure. Based upon Dr. Smith's opinion, we conclude that further material improvement could reasonably have been expected from medical treatment or the passage of time. Therefore, we find that claimant has established that her left knee condition was not medically stationary at the time of the July 1992 closure. Consequently, we find that the claim was prematurely closed.

Extent of disability

Because we find that the claim was prematurely closed, we do not address the issue of extent of permanent disability.

ORDER

The Referee's order dated May 20, 1993 is reversed. The Order on Reconsideration is vacated and the Notice of Closure is set aside as premature. The claim is remanded to the SAIF Corporation for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

Board Members Neidig and Haynes dissenting.

For the reasons expressed in the dissent in Darlene K. Bentley, 45 Van Natta 1719 (1993), we conclude that the majority in Bentley wrongly decided to disavow the Mackey case. However, in the present case, we find additional and different reasons not to continue down the path taken by the majority in Bentley.

Although we disagree with the majority's decision in Bentley, the majority in that case at least attempted to provide a tenuous connection to the court's decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In Bentley, the majority focused on the holding in Smith which provided that ORS 656.268(5) and ORS 656.283(7) allow a referee to consider evidence that could not have been submitted on reconsideration. The Bentley majority then concluded that, given the language of ORS 656.283(7), "extent of disability issues" at hearing should not be limited to those specifically raised at the reconsideration proceeding. Bentley, supra.

Although we believe that the Smith court ruled only on limitations on evidence used in evaluating a worker's permanent impairment, we would suggest that the Bentley majority was correct in finding that Smith pertained to extent of disability cases. In the present case, however, the issue involves premature closure, rather than extent of disability. Smith contains no discussion of which extent issues may be raised at hearing, much less any discussion of the raising of "non-extent" issues. After considering the majority's opinion, we find even fewer persuasive reasons to extend the Bentley holding to the facts of this case.

Here, the parties both had ample opportunity to consider the evidence prior to proceeding through the reconsideration process. Claimant and her attorney determined that the only issues on reconsideration were issues involving temporary disability, impairment findings and scheduled permanent disability. (Ex. 16). Claimant specifically chose not to raise an issue of premature closure at the time of reconsideration.

Accordingly, we reiterate our concern that the reconsideration process is being rendered meaningless by the Board's decisions in cases such as Bentley and the present case. The holding in this case implies that any issue related to a Determination Order may be raised at hearing for the first time, which ignores legislative intent to reduce litigation by addressing issues at the Department level.

Finally, we would also note that the holding of this case may work against claimants in certain circumstances. For example, although an insurer may not contest a claimant's right to temporary disability during the reconsideration proceeding, a carrier may now, apparently, challenge that issue for the first time at hearing. Such actions will likely result in additional requests for continuances or postponements, which will further add to the burden already placed on the system.

For the above reasons, we would affirm the Referee, and would respectfully decline to extend the Bentley decision to cases that do not involve issues of permanent disability.

March 11, 1994 Cite as 46 Van Natta 421 (1994)

In the Matter of the Compensation of
DARRELL D. HENDRIX, Claimant
WCB Case No. 92-12060
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of Referee Black's order which set aside its partial denial of claimant's "current condition." On review, the issue is propriety of the partial denial and, if proper, compensability of claimant's current condition. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded, relying on Guerrero v. Stayton Canning Co., 92 Or App 209 (1988), and Roller v. Weyerhaeuser Co., 67 Or App 583, amplified on recon 68 Or App 743 (1984), that the employer issued a procedurally improper preclosure denial. Although we agree with the Referee that the denial was improper, we do so based on the following reasoning.

Claimant sustained a back injury at work on August 5, 1992. The employer accepted a disabling thoraco-lumbar strain. (Ex. 25). On October 19, 1992, one day prior to its acceptance, the employer issued the following denial:

> "We have accepted your August 5, 1992 industrial injury as a thoracolumbar strain. Information received to date indicates you have recovered from the August 5, 1992 injury.
>
> "[The employer] must respectfully deny your current condition, need for treatment, and any claimed disability as not compensably related to your industrial injury as of the time you saw Dr. Serbu on August 24, 1992." (Ex. 23).

Thereafter, on November 3, 1992, the employer closed the claim with no award of permanent disability. (Ex. 26).

Because the employer accepted a condition at the same time it issued its denial, we interpret the employer's letter to be a "partial denial." In Johnson v. Spectra Physics, 303 Or 49, 58 (1987), the Supreme Court recognized the validity of partial denials, holding that "[t]he insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. That specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial."

Thus, if a carrier denies a portion of a claim, it must do so clearly and with specificity. Weyerhaeuser Co. v. Warrilow, 96 Or App 34, 38 (1989) (partial denial of "degenerative changes with mild osteophytic spurring" was sufficiently specific). Furthermore, while an accepted claim is in open status, a carrier may issue a partial denial of an unrelated condition. Tattoo v. Barrett Business Service, 118 Or App 348, 353-54 (1993) (preexisting spleen condition unrelated to accepted lumbosacral sprain).

Here, however, the employer did not identify a separate condition that it was denying. Instead, although it accepted a specific condition (thoracolumbar strain), it denied only claimant's "current condition" after a specified date. The record does not reveal the existence of a separate condition after August 24, 1992 (the effective date of the employer's denial). Rather, after our review of the record, we agree with the Referee's finding that claimant's condition after August 24, 1992 represented a continuation of complaints and treatment related to the August 5, 1992 work injury. Accordingly, we find that the employer did not deny a specific, unrelated condition. Therefore, we conclude that its "partial denial" is not valid.

On review, the employer argued that its denial was a valid "current condition" denial, consistent with the Board's holding in Daniel R. Bakke, 44 Van Natta 831 (1992). In Bakke, we held that when a carrier obtains evidence that a worker's disability is not then caused in major part by the compensable injury, but rather by a preexisting condition, the carrier may partially deny compensation for the then-current condition. Bakke, supra, 44 Van Natta at 833 (citing ORS 656.005(7)(a)(B)).[1]

Here, however, there is no evidence of a preexisting condition, nor is there evidence of a preexisting condition combining with the compensable injury. See ORS 656.005(7)(a)(B). Although the employer contends that claimant's "functional component" is a preexisting condition because it is part of claimant's character, there is no medical evidence to support the employer's theory. Therefore, although a "current condition" denial may issue on the ground that a compensable injury, which had combined with a preexisting condition, is no longer the major contributing cause of claimant's condition, we find no basis in this record to support such a denial.

Accordingly, we affirm the Referee's order setting aside the employer's October 19, 1992 partial denial, and we remand the claim to the employer for processing in accordance with law.

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 $1,000, 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 claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 7, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the self-insured employer.

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[1] Bakke should be interpreted and applied consistent with Guerrero, supra, Roller, supra, Warrilow, supra, and Tattoo, supra, in that any partial or current condition denial based on ORS 656.005(7)(a)(B) must reflect a specific, separable, unrelated (or no longer related) condition and not a denial of a continuation of the accepted condition.

In the Matter of the Compensation of
DAVID HERNANDEZ, Claimant
WCB Case Nos. 92-14678 & 92-04873
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of those portions of Referee Spangler's order which: (1) awarded interim compensation from January 3, 1992 until SAIF's October 2, 1992 denial; and (2) assessed a penalty for allegedly unreasonable claim processing based on this compensation. In his brief, claimant moves to strike a portion of SAIF's appellant brief which relied on excluded evidence. On review, the issues are motion to strike, interim compensation, and penalties. We grant the motion to strike and modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the fifth paragraph of his ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike the portion of SAIF's brief that relied on evidence not admitted into the record. SAIF agrees that references in its appellant's brief to excluded evidence should not be considered on review. Given SAIF's position, claimant's motion to strike is granted. Lines four through sixteen on page four of SAIF's appellant brief are stricken and are not considered on review.

Interim Compensation

The Referee found that SAIF's insured had notice or knowledge on January 3, 1992 that claimant's back hurt and that he was no longer able to continue working. The Referee concluded that SAIF had a duty to begin payment of interim compensation as of that date. We disagree that the employer had notice or knowledge of a claim on January 3, 1992. Consequently, we modify the Referee's award of interim compensation.

ORS 656.262(4)(a) requires the insurer to begin the payment of interim compensation "no later than the 14th day after the subject employer has notice or knowledge of the claim." A claim "means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6).

In discussing what constituted employer "knowledge of the injury," under ORS 656.265(1)(a), the court, in Argonaut Ins. Co. v. Mock, 95 Or App 1 (1989), stated:

> "'knowledge of the injury' must be sufficient reasonably to meet the purpose of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." Id. at 5.

Here, claimant worked for SAIF's insured since 1987 as a concrete finisher. (Ex. 21B, Tr, 30). Claimant's back has been painful since a 1986 injury with another employer, insured by Safeco. (Tr. 16, 30). In 1991, while working for SAIF's insured, claimant's back pain increased to the point that he told his employer that he had to seek medical treatment. (Tr. 17, 20, 25). In September 1991, claimant

sought treatment from Dr. Olson and Dr. Blake, orthopedic surgeon, for complaints of progressive low back pain without any new injury. (Exs. 14, 15). Claimant was laid off in November or December of 1991 due to bad weather. (Tr. 38, 42). Claimant returned to work in January 1992, and then told the employer that his back hurt too much and he quit. (Ex. A). Claimant again saw Dr. Blake in February 1992. (Ex. 15-2). The doctors' records were sent to Safeco. On March 6, 1992, Safeco denied claimant's claim for aggravation. (Ex. 17). Then, on June 18, 1992, Safeco issued a disclaimer of responsibility naming SAIF's insured as a potentially responsible employer. (Ex. 19A). In response to Safeco's disclaimer, claimant's attorney wrote SAIF, on July 7, 1992, asserting a claim against its insured. SAIF received the letter on July 9, 1992. (Ex. 21A).

At the time that claimant left work on January 3, 1992, SAIF's insured had no reason to believe that claimant had sustained an injury or that his inability to work was a result of his employment. See David J. Pardun, 39 Van Natta 1014, 1015 (1987) (the claimant's physical inability to perform work was insufficient to put the employer on notice of a potentially work-related injury or disease where the claimant had a preexisting back condition). No injury occurred. Claimant merely informed his employer that his back was hurting and that he needed to see a doctor. Claimant did not request to file a workers' compensation claim nor otherwise assert a right to workers' compensation benefits. No doctor's report indicated that claimant's inability to work was due to his work with SAIF's insured.

Based on the above, we find that the employer did not have notice of a claim until July 9, 1992 when SAIF received claimant's attorney's July 7, 1992 letter. SAIF's obligation to commence interim compensation was triggered at that time and continued until it denied the claim on October 2, 1992.

Accordingly, the Referee's order awarding interim compensation from January 3, 1992 to October 2, 1992 is modified. Claimant is entitled to interim compensation from July 9, 1992 until October 2, 1992, less unemployment benefits received. The Referee's penalty assessment based on this interim compensation should be likewise modified. In other words, SAIF shall pay a penalty for its failure to pay interim compensation equal to 25 percent of the aforementioned compensation payable from July 9, 1992 until October 2, 1992 (less unemployment benefits), payable in equal shares to claimant and his attorney.

ORDER

The Referee's order dated July 7, 1993 is modified in part and affirmed in part. The Referee's order is modified to order SAIF to pay interim compensation for the period from July 9, 1992 to October 2, 1992, less claimant's unemployment benefits. The Referee's penalty assessment is modified to award a 25 percent penalty based on this interim compensation, payable in equal shares to claimant and his attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
DIANE L. HOYT, Claimant
WCB Case No. 91-09229
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The self-insured employer requests review of Referee Davis' order that set aside the August 26, 1991 Determination Order and the March 6, 1992 Order on Reconsideration as premature. On review, the issues are premature closure, and alternatively, extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

At the time of claim closure, material improvement in claimant's right shoulder condition reasonably could not have been expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant was not medically stationary at the time of the August 26, 1991 claim closure. We disagree.

A claim shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). It is the claimant's burden to establish that she was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). A claimant's condition and the reasonable expectation of improvement are to be evaluated as of the date of closure, without consideration of subsequent changes in the claimant's condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Service, 72 Or App 524 (1985).

We conclude that the preponderance of the evidence establishes that claimant was medically stationary on August 26, 1991, the date of closure.

On July 2, 1991, claimant's treating physician, Dr. Beck, declared claimant medically stationary. (Ex. 39). However, on July 31, 1991, he withdrew that opinion on the ground the claimant had not received the physical therapy that he had prescribed. (Ex. 41). Thereafter, on August 13, 1991, Dr. Beck again declared claimant medically stationary, even though claimant did not begin physical therapy until August 21, 1991. (See Ex. 45). On February 13, 1993, Beck again changed his opinion, stating that claimant had yet to become medically stationary. (Ex. 64).

On this record, we conclude that claimant was medically stationary on the date of claim closure. This conclusion is strengthened by the fact that in neither his July 31 nor his August 13 note did Dr. Beck propose any specific additional medical treatment for claimant's right shoulder. See Jennifer Matthies, 44 Van Natta 39 (1992).

Dr. Beck's February 1993 report that claimant was not yet medically stationary does not alter our conclusion. The record establishes that Dr. Beck changed his mind regarding claimant's medical status several times. His justification for his initial change of opinion was claimant's failure to obtain physical therapy services. (See Ex. 41). Beyond saying that he had made an error, Dr. Beck offered no explanation for his change of opinion in February 1993. Because Dr. Beck did not offer a reasonable explanation for his final change of opinion, see Kelso v. City of Salem, 87 Or App 630 (1987); see also Moe v. Ceiling Systems, 44 Or App 429 (1980), and because that opinion did not state that Beck expected further material improvement in claimant's condition, see ORS 656.005(17); Robert L. Alder, 44 Van Natta 2472 (1992), we attach little probative weight to it.

In reaching this conclusion, we note that Dr. Beck did not attempt to justify any of his changes of opinion on the ground that he did not understand the meaning of the term "medically stationary." To the contrary, the record establishes that Dr. Beck did understand the meaning of that term. (See Ex. 35). This understanding strengthens our decision to give Dr. Beck's final report minimal weight.

Finally, we do not find it dispositive that claimant began physical therapy five days before the Determination Order issued. We are persuaded that, inasmuch as Dr. Beck had declared claimant medically stationary on August 13, before claimant even began physical therapy, an inference arises that, at most, the therapy was for palliative, not curative, purposes. See Maxine J. Evans, 34 Van Natta 1021 (1982). In any event, there is no medical evidence that claimant's right shoulder condition would materially improve as a result of physical therapy. ORS 656.005(17); see Maarefi v. SAIF, 69 Or App 527, 531 (1984). For these reasons, we discount the fact that claimant began receiving physical therapy shortly before her claim was closed.

In sum, then, we conclude that claimant has not met her burden of proof. The record establishes that she was medically stationary at the time of claim closure. Accordingly, the closure was not premature.

We turn to the remaining issues presented by this case.

Extent of Scheduled Permanent Partial Disability

The Determination Order awarded claimant 5 percent (9.6 degrees) scheduled permanent partial disability for a chronic condition making claimant unable to repetitively use her right arm. On reconsideration, the Department reduced the award to zero, because there were no objective findings of impairment to a scheduled body part. OAR 436-35-010(1). After reviewing the record, we find no objective evidence that claimant has a chronic condition that has limited her ability to repetitively use her right arm. Accordingly, we conclude that the Order on Reconsideration correctly reduced claimant's 5 percent scheduled permanent partial disability award to zero.

Extent of Unscheduled Permanent Partial Disability

The Order on Reconsideration found that claimant had a 5 percent impairment of her right shoulder. (Ex. 65-4). Before the Referee, claimant argued that, in addition to a 5 percent impairment rating for her right shoulder, she was entitled to an impairment rating of 5 percent for a chronic condition making her unable to repetitively use her cervical spine. OAR 436-35-320(5). Because claimant's attending physician did not make objective findings of such an impairment, ORS 656.245(3)(b)(B), OAR 436-35-320(1), and because the preponderance of the medical evidence does not establish that claimant is unable to repetitively use her cervical spine, OAR 466-35-320(5), we do not find that claimant has established that she is entitled to an award for impairment beyond that awarded by the Order on Reconsideration.

ORDER

The Referee's order dated April 13, 1993, is reversed. The August 26, 1991 Determination Order and March 6, 1992 Order on Reconsideration are reinstated and affirmed.

March 11, 1994 Cite as 46 Van Natta 426 (1994)

In the Matter of the Compensation of
KELLY L. KIRKENDAHL, Claimant
WCB Case No. 92-04009
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Garaventa's order that: (1) set aside its "back-up" denial of claimant's low back injury claim; and (2) set aside its denial of claimant's psychological condition. On review, the issues are the propriety of the "back-up" denial and compensability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the insurer's "back-up" denial of claimant's low back injury claim and also set aside the insurer's denial of claimant's psychological condition.

"Back-up" Denial

We adopt the Referee's reasoning and conclusions as set forth in her order.

Psychological Condition

Relying on Boeing Co. v. Viltrakis, 112 Or App 396 (1992), the Referee determined that claimant had established that her December 14, 1990 compensable injury was a material contributing cause of her need for psychological counseling. On this basis, the Referee found the psychological treatment compensable.

Claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990. Accordingly, the 1990 amendments to the Workers' Compensation Act apply to claimant's claim. See Or Laws 1990 (Special Session), ch 2, §54; Ida M. Walker, 43 Van Natta 1402 (1991). Under amended ORS 656.005(7), where a condition or need for treatment is caused by the compensable injury as opposed to the industrial accident, the 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, 113 Or App 411 (1992).

Here, claimant's physician has opined that claimant needs psychological counseling as a result of her physical disability due to the compensable injury. Inasmuch as claimant's psychological condition and need for treatment arose from the compensable injury rather than the industrial accident, claimant must establish that the injury was the major contributing cause of her psychological condition and need for treatment. Albany General Hospital v. Gasperino, supra.

Claimant's attending physician, Dr. Rung, who is not a psychiatrist, believed that claimant needed psychological counseling in order to aid the transition between physical disability due to the injury and a return to work. Dr. Rung did not quantify the contribution of the compensable injury to claimant's need for psychological treatment. The remainder of the medical evidence concerning the causation of claimant's psychological condition and need for treatment comes largely from Dr. Davies, an examining psychologist, and Dr. Kuttner, a psychiatrist. Both Dr. Davies and Dr. Kuttner examined claimant on only one occasion.

Dr. Davies diagnosed chronic dysthymia, factitious disorder, and a personality disorder with passive-aggressive, masochistic and borderline features. Dr. Davies also initially diagnosed probable psychological dependence on prescription tranquilizers, but later withdrew that diagnosis after receiving further information. Dr. Davies opined that claimant's psychiatric problems were longstanding and chronic. He felt that these conditions were unrelated to claimant's compensable injury.

Dr. Gostnell, a psychologist at the pain center claimant attended, and who had evaluated and treated claimant, essentially concurred with Dr. Davies' report.

Dr. Kuttner opined that claimant had actual organic pathology which caused a chronic pain syndrome. He tentatively diagnosed a somatoform pain disorder, although he indicated that this was a presumptive diagnosis since claimant's physical pathology might be sufficient to account for her complaints. Dr. Kuttner opined that the compensable injury and its sequellae were the major contributing cause of claimant's condition. Dr. Kuttner disagreed with Dr. Davies' diagnosis of a factitious disorder.

We read Dr. Kuttner's opinion as addressing the question of whether or not claimant's physical complaints were genuine. Although Dr. Kuttner addressed Dr. Davies' concerns about whether claimant's physical symptoms were real, we find his opinion to be conclusory in that he failed to explain how the compensable injury caused claimant to need psychological counseling. Dr. Kuttner's reports focus mainly on refuting Dr. Davies' assertions that claimant has a factitious disorder or is magnifying pain symptoms or malingering. His reports lack an explanation of how the injury has caused claimant to need psychological treatment. Thus, we do not find his opinion persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Although Dr. Rung opined that claimant needed counseling to help the transition between disability and re-entering the work force, her opinions are likewise conclusory and lacking in explanation.

We further note that Dr. Gostnell, a psychologist at the pain center claimant attended, who had evaluated claimant previously, concurred with Dr. Davies' opinion that claimant's psychological condition was unrelated to her compensable injury. Because we find the opinions of Drs. Rung and Kuttner unpersuasive, and in light of the contrary medical evidence, we conclude that claimant has failed to establish that her compensable injury is the major contributing cause of her need for psychological treatment. Accordingly, we conclude that claimant has failed to establish that her psychological condition and need for treatment is compensable.

Attorney Fees/Hearing Level

The Referee awarded claimant's attorney $4,500 for his services at hearing in overcoming both the "back-up" denial of claimant's low back condition and the denial of claimant's psychological condition. We have reversed that portion of the Referee's order which set aside the insurer's denial of claimant's psychological condition. Accordingly, since we have found the psychological condition not to be compensable, we modify the Referee's attorney fee award for counsel's 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 "back-up" denial issue is $3,000, 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 attorney's statement of services), the complexity of the issue, and the value of the interest involved.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for services on review concerning the "back-up" denial issue. 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 attorney's services on review concerning the "back-up" denial 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 January 25, 1993 as reconsidered on April 12, 1993, is reversed in part, modified in part, and affirmed in part. That portion of the Referee's order that set aside the insurer's denial of claimant's psychological condition is reversed. The denial is reinstated and upheld. The Referee's $4,500 attorney fee award is modified. For services at hearing, claimant's attorney is awarded $3,000 payable by the insurer. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded $850 payable by the insurer.

March 11, 1994 Cite as 46 Van Natta 428 (1994)

In the Matter of the Compensation of
ELIZABETH M. KITZMAN, Claimant
WCB Case No. 93-01172
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Black's order that upheld the SAIF Corporation's denial of her aggravation claim for a right knee condition. On review, the issue is aggravation.

We affirm and adopt the Referee's order with the following supplementation.[1]

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[1] Claimant's brief makes reference to Ex. 27. However, inasmuch as Ex. 27 has not been admitted into the record, we have not considered that exhibit in our review.

Claimant has a preexisting right knee condition (traumatic arthritis) stemming from a serious noncompensable 1967 motor vehicle accident in which claimant drove into a concrete abutment. In that accident, she sustained a pelvic fracture and an ankle fracture in addition to the right knee injury and was hospitalized for 3 to 4 months.

In September 1988, claimant was leaving work as a kindergarten teacher when she caught her shoe on concrete and fell landing on her right knee. She also cracked a tooth, broke her glasses and scratched her face. The claim was accepted for tooth fracture, contusion and strain of the right knee, cervical strain, mild concussion and broken glasses. (Ex. 7).

Dr. Singer performed a partial transarthroscopic lateral meniscectomy, chondroplasty and joint debridement of the right knee. In surgery, Dr. Singer noted extensive degenerative changes. (Ex. 10). The claim was closed in December 1989. (Ex. 15).

On January 22, 1993, SAIF denied claimant's current right knee condition, including preexisting, underlying degenerative arthritis and valgus deformity. (Ex. 23). On January 29, 1993, claimant underwent a right total knee arthroplasty surgery.

At issue here is the compensability of claimant's current right knee condition and need for medical treatment including total right knee replacement surgery. Claimant contends that the 1988 injury caused her preexisting, but relatively stable, right knee arthritis to deteriorate dramatically necessitating right knee replacement surgery. Because her compensable injury combined with her preexisting right knee condition, claimant must establish that the compensable injury is the major contributing cause of her disability and need for treatment. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) (If a work injury renders a preexisting condition symptomatic, the current condition is compensable so long as the injury is the major contributing cause of the worker's resultant need for treatment).

After reviewing the record, we conclude that Dr. Donahoo offers the most persuasive medical opinion concerning the causation of claimant's current right knee condition. Dr. Donahoo opined that the current right knee problem was related to post-traumatic arthritis subsequent to the accident of 1967. Dr. Donahoo further opined that the torn meniscus in 1988 could not have produced the degenerative changes described by Dr. Singer in his surgical report since there was not enough time subsequent to that injury to develop the changes described. Dr. Donahoo believed that the major contributing cause of the need for surgery were the post-traumatic changes related to the 1967 injury. (Ex. 21). We find Dr. Donahoo's opinion well reasoned and based on complete information. Therefore, we find it persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, his opinion is supported by Dr. Strukel's conclusion that the major contributing cause of claimant's need for right knee replacement surgery was post-traumatic arthritis caused by the 1967 motor vehicle accident.

Dr. Lantz performed claimant's right knee replacement surgery. Dr. Lantz opined that there was a "good chance" that the symptomatic changes caused by the 1988 injury accelerated claimant's degenerative osteoarthritis and her need for treatment. Dr. Lantz could not state whether claimant's symptoms or osteoarthritis would have progressed whether or not she had the 1988 injury. Dr. Lantz believed that the meniscal tear was a contributing factor. However, although Dr. Lantz noted many contributing factors including the 1967 motor vehicle accident, obesity and the meniscal tear, he could not state what the percentages of contribution of these factors were. We do not interpret Dr. Lantz's opinion as meaning that it is probable that the 1988 injury accelerated claimant's degenerative arthritis or was the major contributing cause of her need for treatment. Accordingly, we do not find Dr. Lantz's opinion persuasive.

Although Dr. Becker believed that the 1967 injuries set the stage for claimant's current problems, he felt, based on claimant's history, that her current problems dated to the 1988 compensable injury. He believed that claimant had substantial pelvic instability due to the 1967 injury which was compensated for until 1988 when the fall "unbalanced" her system and caused her to rapidly deteriorate. (Ex. 18). We find Dr. Becker's opinion to be lacking in explanation and analysis in that he fails to explain how the 1988 injury "unbalanced" claimant's symptoms. In addition, Dr. Becker failed to explain how claimant's pelvic instability (which he opines was worsened by the 1988 injury) caused her right knee to degenerate faster.

Claimant also relies on opinions from Dr. Singer, who performed claimant's May 1989 right knee meniscectomy surgery. In May 1989, prior to claimant's meniscectomy surgery, Dr. Singer stated that claimant's 1988 accident seemed to have precipitated the major problems with her knee. He suspected that claimant had some of the degenerative arthritis before the 1988 injury, but the accident had caused her to decompensate. Because of the remoteness of his opinion, we do not find Dr. Singer's statements persuasive regarding what is now the major contributing cause of claimant's right knee condition.

ORDER

The Referee's order dated May 26, 1993 is affirmed.

March 11, 1994 Cite as 46 Van Natta 430 (1994)

In the Matter of the Compensation of
TERESA M. MAGANA, Claimant
WCB Case No. 93-01215
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Howell's order which affirmed an Order on Reconsideration awarding 5 percent (16 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

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

The temporary rules set forth in WCD Admin. Order 93-052 applied to all ratings of permanent disability made after June 17, 1993. However, those temporary rules expired on December 14, 1993. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. See Michelle Cadigan, 46 Van Natta 307 (1994).

The permanent rules apply to claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. Accordingly, on review, we do not apply the new permanent rules or the expired temporary rules.

Rather we apply the standards in effect at the time of the Determination Order, which are those containined in WCD Admin. Order 6-1992, effective March 13, 1992. See OAR 436-35-003(2).

ORDER

The Referee's order dated June 4, 1993 is affirmed.

In the Matter of the Compensation of
RAYMOND E. MERIDETH, JR., Claimant
WCB Case Nos. 92-15730 & 92-12427
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Baker's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, SAIF disputes that portion of the Referee's order that: (1) found claimant's current condition compensable; and (2) assessed attorney fees against SAIF. On review, the issues are compensability, responsibility, 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's current low back condition remained compensable and that Liberty remained responsible for that condition. We agree.

Liberty previously accepted a low back strain injury relating to an October 26, 1990 injury that claimant sustained while working for its insured. (Ex. 11). Prior to hearing, both carriers contested compensability of and responsibility for claimant's current low back condition. However, at hearing, Liberty changed its position and denied only responsibility. (Tr. 7). SAIF continued to contest both compensability and responsibility. On review, Liberty contends that it has established that claimant sustained a new compensable injury while subsequently employed at SAIF's insured. Thus, it argues, responsibility for claimant's low back condition should shift to SAIF.

On review, SAIF argues that claimant's current low back condition is not compensable because, it argues, the major contributing cause of that condition is claimant's preexisting degenerative joint disease. In the alternative, SAIF argues that, if claimant's low back condition is compensable, Liberty remains responsible for that condition.

Compensability

Where disability or need for treatment is due to the combination of an injury and a preexisting condition, the injury is compensable only if it is the major contributing cause of the disability or need for treatment. ORS 656.005(7)(a)(B). All of the medical evidence acknowledges that claimant has degenerative joint disease in his lower spine that preexisted the October 1990 compensable injury with Liberty's insured. However, the persuasive medical evidence does not indicate that the current disability or need for treatment is due to the combination of an injury and a preexisting condition.

SAIF relies on the opinions of several medical examiners (IMEs) who opine that the major contributing cause of claimant's current low back condition is his preexisting degenerative condition. (Exs. 12, 13-6, -7, 17-2, 33-5, 43-5, -6). However, none of these IMEs address the cause or effect of claimant's bulging discs at L4-5 and L5-S1, which were revealed by the December 1991 CT scan along with the facet degeneration at those levels. (Ex. 12).

Dr. Danner, claimant's treating physician, disagreed that claimant's current low back condition was caused by his preexisting degenerative condition. Although he acknowledged that claimant had preexisting degenerative arthritis of the low back, he did not find the degenerative condition to be exceptional in claimant's case. (Ex. 22). On the other hand, Dr. Danner opined that claimant's disc bulge at L5-S1 was "most likely" caused by the October 1990 work injury and that the October 1990 injury was the major contributing cause of claimant's low back condition. Id.

Furthermore, a bone scan performed in July 1992 supports Dr. Danner's opinion that the degenerative condition is not the major contributing cause of claimant's low back condition. The bone scan indicated that there was no active degenerative disease. (Ex. 31). Dr. Hubbard, neurologist, ordered the bone scan to determine whether there was active inflammation at L4-5 which might benefit from facet injections. (Exs. 30, 31, 32). The bone scan was completed and compared with the December 1991 CT scan. (Ex. 31). The bone scan was normal, showing no increased activity that would indicate injury or active degenerative disease. Id. On the basis of this bone scan, Dr. Hubbard opined that claimant had a persistent area of muscular discomfort in the low back which was "likely aggravated by some lumbar facet disease although [there were] no obvious areas to inject." (Ex. 32).

Dr. Hubbard provided no opinion as to the cause of the "muscular discomfort" nor did he address claimant's bulging discs. However, we find that the bone scan and Dr. Hubbard's reports support Dr. Danner's opinion that, although present, claimant's degenerative condition did not make a significant contribution to his current low back condition.

Following the bone scan and Dr. Hubbard's reports, claimant underwent two additional IMEs, which reported that the majority of claimant's symptoms were due to his preexisting degenerative condition. (Exs. 33-5, 43-5). However, those IMEs do not discuss the results of the bone scan, which showed no active degenerative disease. (Ex. 31). In addition, they did not address the cause or effect of the bulging discs. For those reasons, we do not find the IMEs persuasive.

Following a MRI in December 1992, claimant underwent a lumbar laminotomy and diskectomy, L5-S1 left, which was performed by Dr. Smith, neurosurgeon, on January 12, 1993. (Ex. 49). However, contrary to Liberty's argument, Dr. Smith gives no opinion regarding causation, although he lists a "July 6th, 1992" injury in the "history" portion of his neurosurgical consultation. (Ex. 43B).

Finally, Dr. Strukel, orthopedic surgeon, performed a record review on February 26, 1993. (Ex. 50). His is the only opinion in the record which has the advantage of having considered the December 1992 MRI, a subsequent myelogram, and the January 1993 operative report. Dr. Strukel opines that, although claimant has preexisting degenerative arthritis, his need for the current surgical treatment was caused by disc herniations, which were in turn caused by the October 1990 work injury. (Ex. 50-6). Strukel's opinion is supported by Dr. Danner's opinion regarding the cause of the initial disc herniations.

We find Dr. Strukel's opinion persuasive because it is based on complete information in that he considered all of the medical tests and procedures in rendering his opinion. Therefore, this record does not establish that any work injury combined with the preexisting disease to cause or prolong the disability or need for treatment. Instead, the need for treatment was caused by the disc herniation at L5-S1, which was in turn caused by the October 1990 injury. Thus, claimant's current low back condition is compensable.

Responsibility

The Supreme Court has held that ORS 656.005(7)(a)(B) is applicable when determining whether responsibility shifts to a subsequent employer under ORS 656.308(1). SAIF v. Drews, 318 Or 1 (1993). In other words, the Court has reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the subsequent accidental injury is not the major contributing cause, the Supreme Court has further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1). Steven K. Bailey, 45 Van Natta 2114 (1993).

Here, there is no dispute that claimant sustained increased pain while lifting buckets of ivy on June 26, 1992 while working for SAIF's insured. The issue is whether this incident constituted a "new injury" within the meaning of ORS 656.308(1), as explained above. SAIF argues that the June 1992 incident did not constitute a new injury. Liberty and claimant argue that it did, noting that the June 26, 1992 incident was a material contributing cause of claimant's disability and need for treatment. However, as noted above, the Court has subsequently determined that the "new injury" must be the major contributing cause of the disability and need for treatment.

Whether claimant sustained a new injury on June 26, 1992, which became the major contributing cause of his disability and need for treatment presents a complex medical issue requiring expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Although noting increased pain following the June 26, 1992 lifting incident in the history portion of his report, Dr. Hubbard renders no opinion as the cause of claimant's current condition, which he ultimately diagnosed as "muscular discomfort." (Exs. 30, 32).

Dr. Smith also gives no opinion regarding the cause of the disc herniation that required surgery, although he mentions a "July 6th, 1992 injury" in the history portion of his surgical consultation report. (Exs. 43B, 49).

In addition, for the reasons discussed in the section on compensability, we do not find persuasive the IME opinions that opined that the cause of claimant's current low back condition was his preexisting degenerative condition. Dr. Edmonds, examining neurologist, and Dr. Fry, examining orthopedic surgeon, were two of the IMEs who gave such an opinion. (Ex. 43-5, -6). However, they also opined that the "specific activity on June 26, 1992 is likely to have contributed to [claimant's] lumbosacral strain and his need for treatment." (Ex. 43-5). Even if we found this portion of their opinion persuasive, it does not raise to the level of major contributing cause. Therefore, it is inadequate to shift responsibility to SAIF.

Following the October 1990 injury and prior to the June 26, 1992 incident, Dr. Danner repeatedly opined that claimant was not medically stationary regarding the October 1990 injury. (Exs. 15, 16, 19, 20, 22, 24, 26). In June 1992, Dr. Danner clarified that claimant was not released to regular work but was instead released to modified work, perhaps on a permanent basis. (Ex. 27B). In addition, as noted above, Dr. Danner related claimant's need for treatment to his herniated discs, which he opined were caused by the October 1990 work injury.

On December 10, 1992, Dr. Danner opined that, due to claimant's increased symptoms following the June 26, 1992 incident at SAIF's insured, claimant's current low back condition and need for treatment was the result of that June 26, 1992 injury. (Ex. 44). He based that opinion on an assumption that claimant's "latest injury may have herniated the L4-5 disc on the left to a greater extent." Id. Dr. Danner ordered a MRI to rule out that possibility. Id. The record contains no subsequent opinion from Dr. Danner.

Contrary to Dr. Danner's assumption, the MRI showed that claimant's herniation at L4-5 had resolved and the herniation at L5-S1 remained the same when compared to the earlier December 1991 CT scan. (Ex. 44A).

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. Danner's opinion that the disc herniations were caused by the October 1990 injury. He did not recant that opinion and, as noted above, the opinion of Dr. Strukel is in accordance with that portion of Dr. Danner's opinion.

However, there are persuasive reasons not to defer to Dr. Danner's opinion that the June 26, 1992 injury was the major cause of claimant's ongoing need for treatment. That opinion was based on the possibility that the June 26, 1992 incident worsened claimant's disc herniation at L4-5. The MRI requested by Dr. Danner showed that this possibility was incorrect. (Exs. 44A). However, the record contains no report from Dr. Danner following that MRI. Therefore, we do not find persuasive Dr. Danner's opinion that the possibility of a worsening of a disc herniation established that the June 26, 1992 incident was the cause of claimant's current low back condition. Gormley v. SAIF, 52 Or App 1055 (1981).

Finally, Dr. Strukel performed a record review and opined that the October 1990 injury caused the disc herniations at L4-5 and L5-S1. The herniation at L4-5 resolved but the one at L5-S1 remained unchanged and was the cause of the need for surgery. (Ex. 50-5, -6). As discussed above, Dr. Strukel is the only physician to consider the MRI, the subsequent myelogram, and the surgery report in rendering his opinion. Because it is well reasoned and based on complete information, we find Dr. Strukel's opinion persuasive.

Therefore, the record does not establish that claimant sustained a new injury within the meaning of ORS 656.308(1) and responsibility for claimant's low back condition remains with Liberty. SAIF v. Drews, supra.

Attorney Fees

The Referee awarded claimant an assessed fee of $2,000 against SAIF. On review, SAIF argues that the fee should not be assessed against SAIF because it is not the responsible carrier. We agree with the Referee's assessment of attorney fees against SAIF.

Prior to hearing, both Liberty and SAIF denied both compensability of and responsibility for claimant's condition. However, at hearing, Liberty changed its position and denied only responsibility. (Ex. 7). On the other hand, SAIF continued to deny both compensability and responsibility at hearing. (Tr. 8).

Under such circumstances, SAIF, as the non-responsible insurer that created the need for claimant to establish the compensability of the claim, is responsible for payment of the attorney fee at hearing. Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993); SAIF v. Bates, 94 Or App 666 (1989). Leland G. Townsend, 45 Van Natta 1074, 1075 (1993); James F. Herron, 45 Van Natta 842, 843 (1993).

Finally, because compensability was an issue on review, claimant is also entitled to an assessed attorney fee under ORS 656.382(2). Although SAIF raised the compensability issue, Liberty as the insurer who requested Board review, is responsible for the attorney fee award under ORS 656.382(2). See SAIF v. Bates, supra.

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 Liberty. ORS 656.382(2). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 31, 1993 is affirmed. For services on review, claimant's counsel is awarded $750, payable by Liberty Northwest Insurance Corporation.

March 11, 1994 Cite as 46 Van Natta 434 (1994)

In the Matter of the Compensation of
JOHN R. NOLAN, Claimant
WCB Case No. 91-11946
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband, and Haynes.

The insurer requests review of those portions of Referee Davis' order that: (1) set aside its "de facto" denial of claimant's depression claim; and (2) set aside the Notice of Closure as premature. On review, the issues are compensability and premature closure.

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

The insurer argues that claimant failed to file a legally cognizable claim for depression. However, inasmuch as the insurer did not raise this defense at hearing, we decline to consider this argument for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, even if we had considered this argument, we would find that, inasmuch as the insurer did not object to claimant raising the depression claim at hearing and, instead, proceeded to litigate the merits of that claim, we find that the insurer waived any procedural defect regarding a premature hearing request on a "de facto" denial. See Thomas v. SAIF, 64 Or App 193 (1983); Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990).

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 and premature closure issues is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 16, 1993 is affirmed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the insurer.

Board Member Haynes dissenting.

Because I would conclude that claimant has not carried his burden of proving the compensability of his depression claim, I dissent.

The compensability of the depression claim rests largely on the medical opinion of consulting psychiatrist Dr. Maletzky, who stated that the December 1989 industrial injury was the direct cause of the depression. Dr. Maletzky apparently based his opinion on the persistence of claimant's pain following the injury. However, at the time of Dr. Maletzky's examination in October 1992, claimant's pain was due not only to the industrial injury, but also to noncompensable fibromyalgia. The fibromyalgia was diagnosed in July 1990 by attending physician Dr. Jones, who also noted some low-grade depression "associated with this pain." (Ex. 20-14).

None of claimant's doctors, including Dr. Maletzky, made a distinction between the pain resulting from the injury and pain resulting from the fibromyalgia. Given this medical record, I cannot determine whether the major cause of the depression is pain due to the injury or pain due to the noncompensable fibromyalgia. I would conclude, therefore, that claimant has not sustained the burden of proving his claim for consequential depression. In addition, because it is undisputed that claimant's physical condition was medically stationary at the time of claim closure, I would conclude that the Notice of Closure was properly issued.

In the Matter of the Compensation of
SUSIE A. FIMBRES, Claimant
WCB Case No. 90-16803
SECOND ORDER ON REMAND
Black , et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Claimant has requested reconsideration of our February 17, 1994 Order on Remand which set aside the insurer's denial of her claim for cervical spondylosis. Specifically, claimant asserts her right to the penalty awarded by Referee Brown in his original order. In response, the insurer contends that claimant is not entitled to a penalty. After considering claimant's motion and memorandum in support, as well as the insurer's memorandum, we issue the following order.

The Referee found that the insurer's denial was unreasonable because the claim was in open status when the denial was issued. Therefore, the Referee assessed a penalty against the insurer. The insurer requested Board review, contending that its denial should be reinstated and upheld.

In our October 8, 1991 Order on Review, without addressing the penalty issue, we affirmed the Referee's order in its entirety. Susie A. Fimbres, 43 Van Natta 2289 (1991). However, on reconsideration, we upheld the insurer's denial and reversed the Referee's order. Susie A. Fimbres, on recon 44 Van Natta 1730 (1992). Although we did not expressly reverse that portion of the Referee's order which had assessed a penalty, such a conclusion was implicit in the order as there were no longer amounts on which to base a penalty.

Subsequently, the court reversed our order and remanded for reconsideration. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993). On remand, we set aside the insurer's denial on the basis that the insurer was precluded from denying claimant's cervical condition under the res judicata doctrine of issue preclusion. 46 Van Natta 298 (1994). We did not address the penalty issue.

In light of the above procedural history, we find it appropriate to address the penalty issue on the merits at this time. We find that a penalty is not warranted, based on the following reasoning.

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 denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time, the insurer issued its denial, both claimant's treating physicians and the Medical Consultants Northwest agreed that claimant's cervical spondylosis was not related to the compensable injury. Moreover, although we have ultimately found that the insurer was precluded from denying claimant's cervical spondylosis on the basis of res judicata, ORS 656.262(6) would still have allowed a "back-up" denial had the insurer's acceptance been made in "good faith."[1] Therefore, we conclude that, in light of the medical evidence and ORS 656.262(6), the insurer had a legitimate doubt as to its liability for claimant's cervical spondylosis condition. In particular, we note that, with regard to ORS 656.262(6), the Board and the Court of Appeals reached opposite conclusions as to its applicability to this situation.

Inasmuch as the insurer had a legitimate doubt as to its liability, we do not find its denial unreasonable. Therefore, penalties are not warranted in this instance and we reverse that portion of the Referee's order that awarded claimant a 25 percent penalty.

Accordingly, our February 17, 1994 order is withdrawn. On reconsideration, as supplemented herein, we republish our February 17, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] We note that ORS 656.262(2) would also allow an insurer to deny a claim that was in "open status." Accordingly, the denial would also not be unreasonable on the basis relied on by the Referee.

March 14, 1994 Cite as 46 Van Natta 436 (1994)

In the Matter of the Compensation of
DEBORAH J. LAYTON, Claimant
WCB Case No. 93-10036
ORDER WITHDRAWING ORDER OF DISMISSAL
Roberts, et al., Defense Attorneys

On February 16, 1994, we dismissed claimant's request for Board review because the record failed to establish that the other parties to this proceeding had received timely notice of claimant's appeal. In the event that claimant could establish that she had provided timely notice to the other parties, we advised her that we were prepared to reconsider our decision.

In response to our order, claimant has submitted a letter stating that she did mail copies of her request for review to the other parties the same day that she mailed her request to the Board.[1] The self-insured employer's counsel has also responded, acknowledging that counsel's office received a copy of claimant's request for Board review in an envelope which carries a postage date of January 12, 1994 (within 30 days of the Referee's December 16, 1993 order).

[1] Claimant's recent submission was a copy of her letter addressed to the Court of Appeals which expressed dissatisfaction with our decision. We have treated the submission as a motion for reconsideration. Notwithstanding claimant's petition for judicial review, we have exercised our authority to withdraw our decision because the 30-day statutory period from our decision has not expired. See ORS 656.295(8); 656.298(1); SAIF v. Fisher, 100 Or App 288 (1990).

In light of such circumstances, we reconsider our February 16, 1994 Order of Dismissal. After conducting our reconsideration, we hold that claimant provided timely notice of her appeal to the other parties. See ORS 656.295(2). We base our conclusion on the following reasoning.

Relying on claimant's unrebutted representation, we are persuaded that she timely mailed copies of her request for Board review to the other parties to this proceeding. See Danny R. Akers, 39 Van Natta 732, on recon 39 Van Natta 813 (1987). This representation is further confirmed by the employer's counsel's submission of a copy of the envelope (carrying a postage date of January 12, 1994) which contained counsel's copy of claimant's request. Furthermore, even if copies of claimant's appeal were not provided to the employer and its claim administrator, in the absence of a showing of prejudice, this timely service of a copy of the request on the employer's counsel is adequate compliance with ORS 656.295(2) to vest this Board with jurisdiction. See Allasandra O'Reilly, 40 Van Natta 1180 (1988).

Accordingly, our February 16, 1994 dismissal order is withdrawn. Inasmuch as claimant's request for Board review is properly before us, we shall prepare this case to conduct our review. A hearing transcript has been ordered. On its receipt, copies will be distributed to the parties and a briefing schedule implemented. Following completion of that briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

March 15, 1994 Cite as 46 Van Natta 437 (1994)

In the Matter of the Compensation of
RICHARD WRIGHT, Claimant
Own Motion No. 93-0757M
OWN MOTION ORDER ON RECONSIDERATION
Robert Guarrasi, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our January 18, 1994 Own Motion Order in which we declined to reopen his claim for the payment of temporary disability compensation on the ground that he had not established he was in the work force at the time of his July 2, 1993 disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our January 18, 1994 order and granted the insurer an opportunity to respond to the motion. We have received the insurer's response. After further consideration, we issue the following order in place of our January 18, 1994 order.

In our January 18, 1994 order, we found that Dr. Maxwell, claimant's treating physician, recommended surgery on July 2, 1993, which is the time of disability.

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). Here, claimant was not working at the time of disability. Therefore, in order to be entitled to temporary disability compensation, claimant must establish that he was willing to work and either that he was making reasonable efforts to find work, or that he was not working because his work-related injury made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proving he was in the work force at the time of disability.

With the request for reconsideration, claimant's attorney submitted a summary of a discussion with Dr. Maxwell, which was verified by Dr. Maxwell on February 14, 1994. In that statement, Dr. Maxwell opined that claimant was temporarily totally disabled throughout 1993, and that claimant's compensable condition made a search for even light or sedentary work futile. Dr. Maxwell's opinion is unrebutted.

Claimant's claim was reopened on September 11, 1991, and he received temporary disability compensation through February 18, 1993. Therefore, the Board found the claimant was in the work force prior to his surgery in 1991. Since claimant's physician stated that claimant was unable to work during 1993, we find that he remained in the work force through the time of his current disability, and therefore, is entitled to receive temporary disability compensation. See Dawkins, supra.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer 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 the insurer 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
GARY A. ESPARZA, Claimant
WCB Case No. 92-16535
ORDER ON REVIEW
Brownstein, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Galton'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 order of the Referee with the following supplementation.

The Referee found the claim noncompensable because claimant failed to prove medical causation. On review, claimant contends that the causation issue is not complex and, therefore, should not require expert medical evidence.

We agree that this is not, on its face, a complex medical question. However, even if this case does not present a complex medical question, claimant must still provide reliable lay evidence to establish that a compensable injury occurred.

Claimant alleges that on Friday, September 11, 1992, he injured his low back at work. However, claimant's various statements as to how the alleged injury occurred are inconsistent. Claimant told Dr. Stahl on September 15, 1992 that he was not sure about the cause of his low back pain, but that he thought it "started after he was lifting some heavy rolls of linoleum." (Exs. 2, 2A). At hearing, claimant first testified that he was injured while attempting to lift up one end of a 300-pound linoleum roll. (Tr. 10-11). Later in his testimony, claimant stated he was lifting a bar which he described as a "very heavy tool." (Tr. 27).

Claimant's supervisor, Mr. Isom, testified that on Tuesday, September 15, 1992, claimant told him he did not know how he got injured. Later that same day, claimant told Mr. Isom that he was hurt "bending over, caulking the boots or picking up the caulking gun." (Tr. 47-48). Similarly, the general foreman, Mr. Schmidt, testified that claimant told him on Tuesday, September 15, 1992, that he did not know how he got hurt but thought that it was probably at work. (Tr. 62-63). However, by Thursday, September 17, 1992, claimant was more specific. Mr. Schmidt testified that claimant said he had injured himself, "when they were raising the roll of linoleum up onto the top of the rack, he was trying to guide it on there and that he thought he had either slipped or twisted while doing that." (Tr. 65).

We also note that on Tuesday, September 15, 1992, when claimant completed his 801 claim form, he indicated in the "remarks" portion that he was not sure how the injury happened. However, on Thursday, September 17, 1992, claimant crossed out this statement and replaced it with "changing lino roll lifted up pipe to put in new roll." (Ex. 1).

On October 14, 1992, claimant gave a statement to the insurer's investigator. On that occasion, claimant again stated his uncertainty with respect to causation. Although he mentioned changing/handling the linoleum roll, he also stated that he thought the strain was "probably a combination of things, plus the bending and sanding." (Ex. 7A, pages 15 and 21).

As a corollary to the mechanism of injury, claimant gives somewhat differing accounts of when he first experienced symptoms. The 801 claim form indicates the pain started when he lifted the "pipe." (Ex. 1). During direct examination, claimant testified that the pain began at home Friday night after work. (Tr. 39-40). Later, during cross examination, claimant again asserted that he definitely felt a strain at the time of the alleged injury. (Tr. 26-27, 29).

Based on this evidence we find claimant has provided various conflicting versions of how he was injured on September 11, 1992, to include lifting various objects, bending while caulking, sanding, or twisting/slipping while adjusting the linoleum roll on the rack. There is also a suggestion in the record that it was the cumulative effect of the work activities on September 11, 1992 that was responsible for claimant's low back strain.

Viewing the lay evidence in a light most favorable to claimant, we find that claimant really has no idea how he injured himself, and he came to blame his work activities because he could not think of any other possible explanation. We are also satisfied that the pain began at some point while claimant was at home, and his accounts of when and how the injury occurred varied greatly because they were nothing more than speculation on his part. In short, there is no reliable lay or medical evidence which establishes that claimant's injury was work-related.

For these reasons, we find that claimant has failed to carry his burden of proof. ORS 656.266.

ORDER

The Referee's order dated March 29, 1993 is affirmed.

In the Matter of the Compensation of
ELIAS GONZALEZ, Claimant
WCB Case No. 93-04456
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Schultz's order that upheld the SAIF Corporation's denial of his right wrist injury claim. On review, the issue is course and scope of employment. We affirm.

FINDINGS OF FACT

Claimant is employed as a nurseryman. He sustained a right wrist fracture while playing basketball during a paid break at work. The employer provides a basketball hoop inside its warehouse as a "diversion" for the workers. Employees are not required to play basketball.

Claimant plays basketball with his friends at work because he enjoys playing basketball. Claimant plays basketball because he has more energy afterwards.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant played basketball primarily for his personal pleasure, and that no "work connection" exists between that activity and claimant's employment, the Referee concluded that claimant's right wrist injury is not compensable. (Tr. 27-30). On review, claimant argues that he played basketball "in order to stay fresh, to reinvigorate himself in order to face the remainder of the workday with sufficient energy." Therefore, claimant contends, he did not play basketball primarily for personal pleasure.

ORS 656.005(7) defines a "compensable injury" as an accidental injury arising out of and in the course of employment. It does not include, however, any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. ORS 656.005(7)(b)(B); Michael W. Hardenbrook, 44 Van Natta 529, aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation, 117 Or App 543 (1992). The statute excludes certain activities from the definition of compensable injury. However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure. See Ester E. Edwards, 44 Van Natta 1065 (1992), aff'd mem Liberty Northwest Insurance Corporation v. Edwards, 118 Or App 748 (1993) (Knee injury incurred during an employer-sponsored volleyball game found compensable, where primary purpose of recreational activity was to enhance interoffice working relationships).

As claimant's injury occurred while he was playing basketball on the employer's premises during his paid afternoon break, our initial inquiry in determining whether claimant's injury arose out of and in the course of employment must, therefore, concern why claimant was playing basketball. It is undisputed that the employer initiated an opportunity for the basketball games during breaks and lunch periods as a "diversion" for the workers. However, no employee is required to play basketball. Claimant testified that he plays basketball with his friends at work because he enjoys playing basketball. Claimant further testified that he plays basketball because he has more energy afterwards. In order to constitute a benefit to the employer, however, the benefit must be beyond an improvement in employee health and morale. Steven M. Chambers, 42 Van Natta 2600 (1990). On these facts, we agree with the Referee that this recreational activity did not have a close work nexus and was performed "primarily" for the worker's personal pleasure.

Moreover, if we analyze claimant's injury under the unitary work connection test, we are also persuaded that there was not a sufficient benefit to the employer to find a work connection between this break-time basketball game and claimant's employment. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). Claimant's wrist injury is not compensable.

ORDER

The Referee's order dated July 14, 1993 is affirmed.

March 16, 1994 Cite as 46 Van Natta 440 (1994)

In the Matter of the Compensation of
LARRY D. JOHNSON, Claimant
WCB Case No. 93-08160
ORDER ON REVIEW (REMANDING)
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Hall and Westerband.

Claimant, pro se, requests review of Referee Myzak's order that: (1) found that claimant's failure to appear at a scheduled hearing was unjustified; (2) dismissed claimant's request for hearing concerning the SAIF Corporation's denial of claimant's current psychological condition; and (3) alternatively, upheld SAIF's denial. Claimant has also moved to strike SAIF's respondent's brief as untimely filed. On review, the issues are motion to strike, dismissal and, potentially, compensability. We deny the motion to strike, vacate the Referee's order, reinstate claimant's hearing request, and remand.

FINDINGS OF FACT

While employed for SAIF's insured, claimant began to experience an authority conflict with his supervisors. (Ex. 1-1). His work productivity fell, and he felt depressed and tearful. (Id). In addition to experiencing extreme disruptions in his sleep, claimant also entertained suicidal thoughts and revenge fantasies. (Id).

In January 1981, Dr. Carter, claimant's treating physician, diagnosed major depression, single episode, and a personality disorder. (Ex. 1). Dr. Carter, as well as several other consulting psychiatrists, related claimant's condition to his work for the employer. (Exs. 6-2, 7-1, 12-1).

Pursuant to a 1982 Stipulation and Order, SAIF accepted a "psychological occupational disease." (See Exs. 14A, 30). Claimant's psychological condition claim was closed in 1983 with a 25 percent unscheduled permanent disability award, (Ex. 20A-1), and subsequently reopened for vocational rehabilitation; the claim was finally closed in January 1986. (Ex. 24B-1). Claimant's permanent disability award was not changed.

On October 10, 1992, claimant sought treatment at a Eugene hospital emergency room. He was depressed and disoriented, and made suicidal threats. (Ex. 26-1). Dr. Reaves, psychiatrist, diagnosed bipolar disease, depressed phase, moderate condition. (Exs. 26-6, 27-3). Claimant was hospitalized for four days, during which his condition was stabilized with Lithium. (See Ex. 28).

Claimant submitted his hospital bills to SAIF for payment. (See Ex. 29-1). At SAIF's request, claimant was examined by Dr. Glass, psychiatrist. (Ex. 29). Dr. Glass opined that claimant's current psychological condition was not related to his 1981 work exposure, but rather was caused by constitutional and developmental factors. (Ex. 29-9, -10). Dr. Glass further opined that the major contributing cause of claimant's current need for psychiatric care was his chronic psychiatric illness, not his 1981 work exposure. (Ex. 29-10).

SAIF denied claimant's current psychological condition on May 17, 1993. (Ex. 30). Thereafter, Dr. Turco, psychiatrist, performed a records review and opined that claimant's chronic psychological condition had developmental and biological origins. (Ex. 31-3). He also concurred with Dr. Glass' opinion regarding medical causation. (Ex. 31-3).

On July 14, 1993, claimant's former counsel filed a request for hearing regarding claimant's current psychological condition. The same day, claimant filed a hand-written request for hearing. Thereafter, claimant's former counsel withdrew his representation.

The hearing was scheduled for 11:00 a.m. on October 5, 1993. Prior to the hearing, claimant submitted an affidavit to the Referee, in which claimant attested that he was "not coming to that hearing because it will be the same as being handcuffed on the ground with guns at my head. I have to avoid situations that will cause problems for me. Winter is coming and I can't afford to be wandering around for the next few months * * *." (Ex. A-6).

The hearing convened at 11:44 a.m. on October 5, 1993. Neither claimant, nor a representative for claimant, attended the hearing. On SAIF's motion, the Referee dismissed claimant's hearing request on the ground that, pursuant to OAR 438-06-071(2), claimant had abandoned the hearing request.

On October 29, 1993, the Referee issued an order dismissing claimant's hearing request. In the alternative, the Referee found no medical evidence to support the compensability of claimant's current condition.

Claimant requested reconsideration of the Referee's dismissal, contending that he did not attend the hearing because:

> "I did not want to get screwed up or in the alternative you and anyone else might have got real screwed up who were also present at that hearing. * * * Had I attended the hearing, it would have or could have been the most extraordinary hearing you ever held, if not the last one. * * * I thought my notarized affidavit would suffice as an appearance[.] * * * I made a good faith effort to appear under the circumstances." Claimant's letter Request for Reconsideration at 1-2.

The Referee granted the motion for reconsideration and adhered to and republished the original order.

FINDINGS OF ULTIMATE FACT

Claimant has established extraordinary circumstances justifying his failure to attend the hearing.

The record is insufficiently developed for review of the compensability issue.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

On December 22, 1993, claimant filed his appellant's brief along with his request for review. The Board mailed the transcript and briefing schedule to the parties on January 3, 1994. On January 7, claimant filed a "Notice of Brief," notifying the Board and SAIF that he had already filed his brief.

SAIF had 21 days after the date of filing of claimant's appellant's brief within which to file its respondent's brief. OAR 438-11-020(2) (as amended WCB Admin. Order 1-1993). Claimant filed his brief prematurely, in that, on the date of filing, the transcript had yet to be mailed to the parties. Therefore, we will not consider that premature filing to calculate SAIF's response time. Because claimant filed his January 7 "Notice of Brief" after the transcript had been mailed to the parties, we will calculate SAIF's response time as of January 7.

SAIF filed its respondent's brief on January 28, 21 days after claimant filed his "Notice of Brief." Because SAIF had 21 days in which to file its respondent's brief, OAR 438-11-020(2), we conclude that its brief was timely filed. Accordingly, we deny claimant's motion to strike.

Dismissal

The Referee concluded that, because there was no extraordinary circumstance or other justification for claimant's failure to attend the hearing, claimant had abandoned his request for hearing. Claimant argues that his precarious psychological status is a sufficiently extraordinary circumstance to justify his failure to appear. We agree.

Unjustified failure of a party or a party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-06-071(2). If a party that waives appearance is the party that requests the hearing, the referee shall dismiss the request for hearing unless extraordinary circumstances justify postponement or continuance of the hearing. Id. A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement." OAR 438-06-081.

We have interpreted these rules to allow a party alleging extraordinary circumstances the opportunity to establish such circumstances for the purpose of justifying his or her nonappearance at a scheduled hearing. We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989).

We interpret claimant's "Request for Reconsideration" to the Referee to be a motion for postponement. See Ray Eaglin, 43 Van Natta 1175 (1991). Inasmuch as the Referee has already ruled on that "motion," we proceed with our review.

Claimant argues that his psychological condition was so fragile that, were he to attend the scheduled hearing, he could have been a danger to himself and other persons present. Claimant relies on his pre-hearing affidavit in support of his contention that this condition constituted an extraordinary circumstance sufficient to justify his failure to attend the hearing. Claimant's affidavit is unrebutted.

OAR 438-06-081 provides several examples of what does not qualify as an extraordinary circumstance beyond a party's control. See Wonder Windom-Hall, 43 Van Natta 1723, on recon 43 Van Natta 1886 (1991). Subsection (2) states, inter alia, that "unwillingness to appear" does not justify a postponement. We conclude that this case is not subject to that provision.

Standing alone, the phrase "unwillingness to appear" suggests that a party's unwillingness to appear will per se fail to qualify as an extraordinary circumstance. However, reading that phrase in the context of subsection (1)'s qualifying language, "beyond the control of the party or parties requesting postponement," we conclude that, if a party's unwillingness to appear is the result of extraordinary circumstances beyond the party's control and the unwillingness is a reasonable forseeable response to those circumstances, the party will be justified in failing to appear at the hearing.

Applying this standard, we conclude that claimant was justified in failing to attend the hearing. The record establishes that claimant has a debilitating, unpredictable psychological condition that has radically affected his ability to interact with other people. Based on claimant's unrebutted affidavit, and the arguments set forth in his "Request for Reconsideration," it is apparent that claimant feared that he might seriously harm either himself or the Referee or others present if he attended the hearing. Moreover, no subpoena had been served on claimant to require his attendance for testimony. We conclude that these events constitute extraordinary circumstances and that claimant's unwillingness to appear was the result of those circumstances. We further conclude that, in light of the potential for physical or other harm to claimant and others, claimant's refusal to attend the hearing was excusable. Claimant has sufficiently justified his failure to attend the hearing.

For the foregoing reasons, we vacate the Referee's dismissal and reinstate claimant's hearing request.

Compensability

As an alternative to dismissal, the Referee reviewed the medical evidence and concluded that claimant's current psychological condition was not compensable. Because we have vacated the Referee's dismissal, we proceed to review the Referee's conclusion regarding this issue.

The Referee found that claimant had failed to establish the compensability of his current need for medical treatment. Because the current record does not specifically identify claimant's accepted psychological occupational disease, and because no medical opinion addresses the relationship between the accepted condition and claimant's current need for treatment, we are unable to conduct the appropriate legal analysis.

In other words, it is unclear whether the parties are litigating this matter as a medical services claim or as a consequential or resultant condition claim. If it is the former, claimant need only establish that his accepted psychological condition materially contributed to his current need for medical services. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484 (1993). If it is the latter, claimant must prove that his current condition is a consequence of or resulted from his accepted psychological condition and that the accepted condition was the major contributing cause of his current condition. ORS 656.005(7)(a)(A), (B).

SAIF denied claimant's current claim on May 17, 1993, on the ground that his accepted psychological condition was no longer the major contributing cause of his current need for treatment. (Ex. 30). According to that denial, and the parties' 1982 stipulation, claimant's 1981 claim was for "psychological occupational disease." (Exs. 14A, 30). The medical evidence consists of claimant's hospitalization records and two medical examiner reports. We conclude that none of that evidence adequately addresses the correct issue.

To begin with, other than a general reference to a "psychological occupational disease" and a "psychological condition" in the parties' 1982 stipulation and SAIF's May 1993 denial, the record is silent regarding the identity of claimant's accepted condition. Specifically, the record lacks an "801" form regarding claimant's original claim, SAIF's original denial, and/or any official claim acceptance. Hopefully, such evidence, in conjunction with the contemporaneous medical reports, will further clarify or identify claimant's accepted condition.

Without such information regarding claimant's accepted condition, we are unable to properly analyze the current medical opinions. According to Dr. Reaves, the psychiatrist during claimant's 1992 hospitalization, claimant's history included a bipolar disorder that was first treated in 1980. (Ex. 27-1). Dr. Reaves stated that claimant's history was consistent with that disorder. (Ex. 27-3). Dr. Reaves diagnosed bipolar disorder, depressed phase, moderate severity. (Id).

SAIF's examiners were Drs. Glass and Turco. On the basis of claimant's history and examination, Dr. Glass diagnosed bipolar and personality disorders. (Ex. 29-8, -9). He opined that claimant's current psychological condition preexisted his 1981 work exposure at the employer. (Ex. 29-9). This led Dr. Glass to conclude that the major contributing cause of claimant's current need for psychiatric care was his chronic psychiatric illness, not his 1981 work exposure. (Ex. 29-10).

Dr. Turco conducted a records review and diagnosed bipolar and personality disorders that preexisted claimant's 1981 work exposure with the employer and that had developmental and biological origins. (Ex. 31-3). He also concurred with Dr. Glass' opinion regarding medical causation. (Id).

Neither Dr. Reaves, Dr. Glass nor Dr. Turco addressed in sufficient detail the relationship between claimant's current and accepted psychological conditions. Other than mentioning claimant's reported history of a bipolar disorder, Dr. Reaves does not address the relationship, if any, between that disorder and claimant's current and accepted conditions. Drs. Glass and Turco opined that claimant's current psychological condition preexisted his 1981 work exposure and, therefore, was not causally related to that work exposure. Those opinions miss the mark. The real issue is whether claimant's current condition is related to his accepted "psychological occupation disease," not whether his current condition is related to his 1981 work exposure.

For these reasons, we find the record insufficiently developed with respect to the identity of claimant's accepted psychological condition and the relationship between claimant's current and accepted conditions. Accordingly, we remand the case to Referee Myzak with instructions to allow both parties the opportunity to submit additional evidence on those issues. See ORS 656.295(5). The submission of this additional evidence may be accomplished in any manner that the Referee determines achieves substantial justice.

Finally, considering the medical and legal complexities of this case (both procedurally and substantively), we encourage claimant to seek the assistance of counsel to aid him in securing evidence that will address the issues discussed in this order. See OAR 438-06-100.

ORDER

The Referee's order dated October 29, 1993, as reconsidered November 29, 1993, is vacated. Claimant's request for hearing is reinstated. This matter is remanded to Referee Myzak for further proceedings consistent with this order.

March 16, 1994 Cite as 46 Van Natta 444 (1994)

In the Matter of the Compensation of
PAUL D. MONROE, Claimant
WCB Case No. 92-06992
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Referee Spangler's order which: (1) declined to consider a "post-reconsideration order" exhibit from claimant's treating physician; and (2) affirmed an Order on Reconsideration that awarded no permanent disability. On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On July 13, 1992 (following the May 18, 1992 Order on Reconsideration), claimant's treating physician, Dr. Stanley, completed a Work Status form (Exhibit 11) that indicated claimant was able to return to work, but was restricted from prolonged repetitive use of both hands for more than three hours at a time.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee declined to consider Exhibit 11 because it had been prepared after the May 18, 1992 Order on Reconsideration. We agree, but we base our conclusion on the following reasoning.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court considered the admissibility of documents at hearing in view of ORS 656.268(5). That statute limits the evidence that may be submitted at the reconsideration proceeding to that which corrects erroneous information and medical evidence that should have been submitted by the attending physician at the time of claim closure. Finding that ORS 656.283(7), which pertains to the presentation of evidence at hearing, contained no similar limitation, the court held that a Referee may consider evidence that could not have been submitted to the Director on reconsideration. Id.

ORS 656.283(7) directs referees to evaluate a worker's permanent disability as of the time of the reconsideration order. We have interpreted this provision as designating a point in time at which a worker's permanent disability is evaluated. Gary C. Fischer, 46 Van Natta 60 (1994). Thus, while the statute does not provide a clear limitation on medical evidence concerning a worker's permanent disability, it does affect the relevancy of evidence that does not address a worker's condition at the pivotal "rating date" (the date of the reconsideration order). Id.

Whether "post-reconsideration" medical evidence is probative is determined on a case-by-case basis. Fischer, supra. Factors supporting consideration of such evidence include the absence of any change in the worker's condition between the reconsideration order and the examination; the performance of "new" tests on the same condition; or the performance of the same tests if prior testing was not valid.

Here, Exhibit 11 is a Work Status form indicating that claimant was able to return to work, but was restricted from prolonged repetitive use of both hands for more than three hours at a time. The form was signed by claimant's treating physician, Dr. Stanley, on July 13, 1992, two months after the reconsideration order issued. Although it is apparent that claimant was seen by Dr. Stanley on or near July 13, 1992, the record contains no medical examination report following the Order on Reconsideration. Furthermore, the Work Status form contains no evidence with regard to whether claimant's condition had or had not changed between the May 18, 1992 reconsideration order and the date the Work Status form was signed. The form also does not indicate that it is addressing claimant's condition as of the date of the reconsideration order. Gary C. Fischer, supra.

Claimant contends that his condition at the time Exhibit 11 was authored was no different than at the time of reconsideration. However, Dr. Stanley's last medical report, on November 11, 1991, states that claimant was medically stationary and that he has a "normal functioning right hand and has no restrictions."[1] (Ex. 7A). There is no other medical evidence in the record until the July 13, 1992 Work Status form.

In light of such circumstances, we conclude that it is more likely than not that the Work Status form is addressing claimant's condition as of a date subsequent to the date of the Order on Reconsideration. Accordingly, we conclude that the report is not relevant and agree with the Referee that it should not have been considered.

Permanent Disability

Inasmuch as Dr. Stanley's last medical report prior to claim closure stated that claimant has no restrictions with his right hand, we adopt the Referee's conclusion that claimant has not proven a chronic condition limiting repetitive use.

ORDER

The Referee's order dated April 20, 1993 is affirmed.

[1] Although Dr. Stanley indicated in the report that claimant's left hand was symptomatic, only the right hand condition has been accepted.

In the Matter of the Compensation of
RHONDA P. STOCKWELL, Claimant
WCB Case No. 92-10494
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Mongrain's order which held that the self-insured employer's termination of temporary total disability benefits was proper. On review, the issue is entitlement to temporary total disability benefits.

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

ORS 656.268(3)(c) provides that an employer may terminate temporary total disability if 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. Such a modified work offer must strictly comply with the requirements of OAR 436-60-030(5). Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610, 613 (1986).

In this case, the parties stipulated that the employer's job offer complies in all respects with OAR 436-60-030(5). Under such circumstances, we conclude that the employer properly terminated temporary total disability benefits in compliance with ORS 656.268(3) and OAR 436-60-030(5).

ORDER

The Referee's order dated April 2, 1993 is affirmed.

Board Member Gunn dissenting.

Claimant, a reservation manager, suffered a compensable right knee injury which eventually necessitated surgery. After her injury, claimant moved from Portland to Medford with her husband who worked for the same employer and had been transferred to Medford. The employer offered claimant a modified job as a reservation manager (claimant's regular job) in Portland. Claimant's physician has restricted claimant from riding or driving more than 30 minutes. On July 9, 1992, claimant declined the job offer requesting work in the Medford area. On July 27, 1992, claimant wrote to the employer stating that she would be unable to accept the position due to her physician's limitations against driving for more than 30 minutes. The employer then reduced claimant's temporary total disability to temporary partial disability pursuant to ORS 656.268(3)(c).

One of the paramount policies underlying the workers' compensation laws is to "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). The specific policy underlying ORS 656.268(3)(c) is to encourage employers to provide work for injured workers who are not yet able to perform their customary work and to preclude workers, who are physically able to do modified work, from continuing to draw full benefits when remunerative work is available to them.

The policy underlying ORS 656.268(3)(c) is frustrated where an employer can terminate a worker's temporary total disability by offering a position at a geographically remote location with the expectation that the worker will refuse the offer. Under such an interpretation of ORS 656.268(3)(c), an employer has no incentive to aid in the injured worker's return to work, because it is cheaper for the employer to offer the worker a sham position that he or she is unlikely to accept.

Here, the employer offered claimant a job in Portland, knowing that it had transferred claimant's husband to Medford. The employer was well aware that claimant was unlikely to accept the modified job in Portland. Under the majority's interpretation of ORS 656.268(3)(c), the employer can offer claimant a job which it knows claimant cannot accept and then terminate claimant's temporary total disability benefits without truly complying with the intent behind the statute. This is not a just result and is inconsistent with the policy behind ORS 656.268(3)(c).

The employer's modified work offer is neither bona fide nor reasonable. Under the circumstances, I would conclude that claimant's temporary total disability benefits should continue until such time as the employer offers claimant modified work in good faith. I dissent.

In the Matter of the Compensation of
BONNI J. MEAD, Claimant
WCB Case Nos. 93-03486 & 93-02288
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Roberts, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Crumme's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the American International Adjustment Company's (AIAC) denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDING OF FACT

The June 22, 1991 compensable injury at AIAC's insured remains the major contributing cause of claimant's low back condition.

CONCLUSIONS OF LAW AND OPINION

On October 15, 1990, claimant injured her low back while working for AIAC's insured. AIAC accepted the claim which was closed with no award of permanent disability. On June 22, 1991, claimant suffered a second compensable injury (diagnosed as a chronic lumbosacral strain) while working for AIAC's insured. This claim was accepted.

On March 18, 1991, claimant suffered worsened symptoms from her chronic lumbosacral strain while employed by Liberty's insured. On February 4, 1993, Liberty accepted the claim for "temporary exacerbation of chronic lumbosacral strain." (Ex. 30). On the same date, Liberty partially denied claimant's current chronic lumbosacral strain condition. (Ex. 29). AIAC denied responsibility for claimant's low back condition on March 10, 1993. On May 14, 1993, Liberty issued a second partial denial of claimant's current low back condition. Liberty's denials did not contain disclaimers of responsibility.

The Referee found that claimant sustained a new compensable injury at Liberty's insured and that, consequently, responsibility for claimant's low back condition shifted to Liberty. On review, Liberty contends that since claimant's current condition results from her injury at AIAC's insured, AIAC remains responsible for that condition. Based on the following reasoning, we agree that responsibility remains with AIAC.

Subsequent to the date of the Referee's order, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). Drews held that the "major contributing cause" requirement of ORS 656.005(7)(a)(B) applies to the shifting of responsibility among employers under ORS 656.308(1) regardless of whether the "preexisting" condition referred to in ORS 656.005(7)(a)(B) was compensable.

Only two medical opinions address the causation of claimant's current low back condition. Dr. Pentecost, claimant's attending physician, believes that claimant's current low back condition is a temporary exacerbation of the compensable injury at AIAC's insured. (Exs. 19; 24). Dr. Pentecost has opined that the June 22, 1991 compensable injury at AIAC's insured remained the major contributing cause of claimant's disability and need for treatment. (Exs. 21; 24; 39-2).

Dr. Rosenbaum, examined claimant and issued a medical report on Liberty's behalf. Dr. Rosenbaum opined that claimant's current condition was related to the compensable injuries she sustained at AIAC's insured. (Ex. 34-4). Dr. Pentecost concurred with Dr. Rosenbaum's opinion. (Ex. 35).

Based on the uncontroverted opinions of Drs. Pentecost and Rosenbaum, we conclude that the major contributing cause of claimant's current low back condition is the June 1991 injury at AIAC's insured. Therefore, claimant has not established that she sustained a new compensable injury at Liberty's insured. Thus, responsibility for claimant's current low back condition never shifted to Liberty and remains with AIAC. SAIF v. Drews, supra.

AIAC contends that since Liberty did not issue responsibility disclaimers, it is precluded from contending that another carrier is responsible for claimant's claim. See Byron E. Bayer, 44 Van Natta 1686, 1687 (1992). Although Liberty may not contend that another carrier is responsible for claimant's low back condition, responsibility for claimant's condition never shifted from AIAC. Since claimant did not suffer a new compensable injury at Liberty's insured, claimant's current low back condition is not compensable as to Liberty, and responsibility for that condition remains with AIAC. Accordingly, we uphold Liberty's denial on compensability grounds, notwithstanding Liberty's noncompliance with the responsibility disclaimer provision of ORS 656.308(2). See Rachel I. Dressler-Iesalnieks, 45 Van Natta 1792 (1993).

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 (19920, mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for services on 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 AIAC. 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 17, 1993 is reversed in part and affirmed in part. That portion of the Referee's order that set aside Liberty's compensability denial is reversed. Liberty's denial is reinstated and upheld. AIAC's denial is set aside and the claim is remanded to AIAC for processing according to law. The Referee's award of a $2,250 attorney fee at the hearing level shall be paid by AIAC. For services on review, claimant's attorney is awarded $750, payable by AIAC. The remainder of the Referee's order is affirmed.

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

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Bethlahmy's order which set aside its denial of claimant's eye injury claim. In his respondent's brief, claimant requests a penalty for unreasonable denial. On review, the issues are jurisdiction, compensability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

In her March 31, 1992 order, the Referee dismissed claimant's request for hearing on the ground that claimant failed to establish good cause for failing to timely file his request for hearing. We reversed and remanded the matter to the Referee for a hearing on the merits. Alfred Mota, 45 Van Natta 63 (1993). The employer filed a timely petition for judicial review of our January 14, 1993 order. The court on its own motion dismissed the petition on the ground that our order was not a final order and, therefore, not subject to judicial review.

The employer again contends that claimant failed to establish good cause for failure to timely file a request for hearing. Our prior order sufficiently explains the rationale finding good cause. Thus, we find it unnecessary to further respond to the employer's argument. We, therefore, incorporate by reference our prior order, which held that claimant had established good cause for untimely filing his request for hearing. Alfred Mota, supra.

Compensability

We affirm and adopt the Referee's conclusion with respect to this issue.

Penalty under ORS 656.262(10)

The Referee found that the evidence failed to establish that the employer was provided with information which would make its denial unreasonable. The Referee concluded that the employer had a legitimate doubt as to its liability for the claim and that, therefore, the denial was reasonable.

The reasonableness of the employer's denial must be gauged based upon the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). If the employer based its denial upon a legitimate doubt as to its liability, the denial is not unreasonable. However, the continuing validity of a denial in light of new medical evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability. Id.

Claimant contends that, prior to hearing, evidence was available, although not in the carrier's possession, which established compensability of the claim. Claimant, thus, contends that the denial was unreasonable thereby warranting a penalty under ORS 656.262(10).

The claims supervisor testified that she investigated the claim before issuing the June 28, 1991 denial. At the time the denial issued, she had records from various physicians, but had not yet talked with Dr. Denman, claimant's treating physician, nor had she received records from Dr. Handelman. (Tr. 31-35, 40, 43). Moreover, after the issuance of the denial, the information she received from Dr. Denman led her to believe that the claim was not valid, because of the discrepancy between what claimant reported to Dr. Denman and what she had been informed about the nature of the work. (Tr. 23-24, 36-37, 52, 53).

Based on the claims supervisors' testimony, we find that the employer had a legitimate doubt as to its liability. Accordingly, because the denial was reasonable, no penalty is warranted.

Attorney Fees on Review

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 issues is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability 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 16, 1993 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the self-insured employer.

March 17, 1994 Cite as 46 Van Natta 450 (1994)

In the Matter of the Compensation of
KAREN J. RICHTER, Claimant
WCB Case Nos. 92-10148 & 92-09658
ORDER ON REVIEW
Gary D. Taylor, Claimant Attorney
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's low back 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

Claimant has an accepted low back condition claim as a result of a February 1983 work injury. Following a permanent disability award of 5 percent, claimant reinjured her low back in December 1984. That claim also was accepted. Claimant was awarded 28 percent permanent disability based on the December 1984 injury.

Claimant continued to experience low back and left leg symptoms. A March 1987 MRI was interpreted as showing a disc herniation at T12-L1 with encroachment upon the thecal sac and spinal canal. (Ex. 6A). An April 1989 MRI showed similar results. (Ex. 13). A June 1990 MRI also was interpreted as showing a bulge at T12-L1. (Ex. 24). The report further found "mild compression fracture deformity of L1 with associated degenerative disc disease at the L1-2 level" and "moderate spinal stenosis across the L1-2 level[.]" (Id.) An April 1992 MRI found no changes. (Ex. 31).

Dr. Kendrick, neurosurgeon, treated claimant on referral from claimant's primary treating physician, Dr. Bomengen, family practitioner. Dr. Kendrick attributed claimant's symptoms to the herniated disc at T12-L1. (Ex. 19). Furthermore, he indicated that the condition related in major part to claimant's prior work injury. (Exs. 12, 19B, 31A, 34). Dr. Kendrick has noted that the condition is not degenerative and that claimant's symptoms have been "more or less continuous since her 1983 injury." (Exs. 31A-1, 34).

Claimant was examined by Drs. Coletti, orthopedist, and Barth, neurologist, in December 1989 at SAIF's request. The panel found "thoracolumbar sprain" and "degenerative disc disease of the thoracolumbar spine." (Ex. 20-3). The physicians also indicated that claimant did not exhibit "any symptoms, signs or diagnostic imaging findings of any pressure on any neural structures." (Id.) Therefore, the panel found that none of claimant's symptoms were attributable to the T12-L1 disc. (Id. at 4). Instead, the panel found that claimant exhibited an "established pain syndrome" that appeared by history to relate exclusively to the 1983 injury. (Id.)

Dr. Bomengen did not concur with the report, stating that the MRI had been interpreted as showing evidence of neural compression. (Ex. 21). Dr. Bomengen later reported to claimant's attorney that the condition at T12-L1 "related back to [claimant's] March of 1983 injury" because she had "no intercurrent injury or process or change in activity or vocation during that time[.]" (Ex. 33A-1). Dr. Bomengen further indicated that the MRI findings were "compatible with degenerative disc disease" and that claimant most likely was experiencing a "post-traumatic degenerative process * * * that can accelerate the degenerative process." (Id.)

Claimant then underwent a second examination at SAIF's request by Drs. Mendius, neurologist, and Ayers, orthopedic surgeon. Their report stated that the MRI indicated a "bulging annulus at [T12-L1] but that [sic] does not appear to be significant nerve root impingement." (Ex. 35-5). Instead, the panel found that the "major contributing cause of [claimant's] present condition appears to be the thoracolumar stenosis at L1-L2 which may have been moderately exacerbated by the work injury of 1983." (Id. at 6). Finally, the panel indicated that claimant had a preexisting T12 or L1 compression fracture which likely had contributed to the bulging annulus and that claimant's industrial accidents probably were not the "major cause of her current condition but may have in some small way contributed to her current condition." (Id. at 7). Dr. Bomengen concurred with the report. (Ex. 36).

We first find that Dr. Kendrick's opinion is not persuasive. As the Referee notes, it is conclusory; Dr. Kendrick offers no explanation of why the bulging disc necessarily is the cause of symptoms or why the condition was caused by claimant's prior accidental injuries. Furthermore, his opinion is contradicted by that of Dr. Bomengen and the panel of Drs. Mendius and Ayers, all of whom indicated that claimant's symptoms were caused by a degenerative disc condition. Consequently, we conclude that Dr. Kendrick's opinion is not persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Furthermore, we disagree with the Referee that Drs. Mendius and Ayers provided an inconsistent opinion because their report first indicated that the 1983 work injury exacerbated claimant's stenosis and then subsequently stated that the industrial accidents may have contributed to claimant's "current condition" only in a "small way." The latter statement was made in the context of the effect, if any, of the preexisting T12 or L1 compression fracture. Therefore, the panel's reference to "current condition" is most reasonably construed as relating to the compression fracture and not claimant's overall condition. In other words, we interpret the panel as indicating that the industrial accidents exacerbated the stenosis, and that such condition was the major cause of claimant's symptoms, but that the accidents had little effect on the compression fracture.

Furthermore, we find that the preponderance of medical evidence shows that claimant's symptoms were caused by her degenerative condition. According to Dr. Bomengen and Drs. Mendius and Ayers, claimant's prior accidents "accelerated" or "exacerbated" the condition. Based on this evidence, we find that the degenerative condition preexisted claimant's 1983 and 1984 accidents and that the compensable injuries combined with the degenerative condition, resulting in a need for treatment or disability. Thus, claimant must show that the compensable injuries are the major contributing cause of her need for treatment and/or disability. See ORS 656.005(7)(a)(B).

Although Dr. Bomengen initially reported that claimant's industrial accidents accelerated the degenerative process, he did not quantify the effect of such events. Drs. Mendius and Ayers stated only that the 1983 injury "may have moderately" exacerbated claimant's stenosis. We find that such language is not sufficient to show that either compensable injury (separately or in combination) was the major contributing cause of claimant's need for treatment. In light of Dr. Bomengen's concurrence with the report, we conclude that claimant failed to carry her burden of proof under ORS 656.005(7)(a)(B). Consequently, she did not prove compensability.

Finally, we note that, contrary to the Referee's finding, SAIF's failure to appeal the August 1989 Determination Order does not establish compensability. See Walter Moore, 45 Van Natta 2073 (1993) (unappealed Determination Order does not preclude litigation of compensability for purposes of res judicata).

ORDER

The Referee's order dated May 27, 1993 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

Board Member Gunn dissenting.

I dissent. The record in this case shows that claimant's current low back symptoms were caused by her prior industrial accidents. Therefore, I would find that claimant proved compensability.

To begin, there are numerous studies showing that claimant suffers from a bulging disc. According to claimant's treating physicians, Drs. Bomengen and Kendrick, claimant's symptoms have been at a consistent level since her 1983 and 1987 injuries. In view of the documented bulging disc and consistency of symptoms, Dr. Kendrick's opinion that claimant's symptoms are due to the bulging disc is more reasonable than attributing her condition to a degenerative disease, which by definition becomes worse over time.

Furthermore, claimant had no additional accidents after 1987. In the absence of an intervening event, I consider Dr. Kendrick's opinion that claimant's work injuries caused the bulging disc to be persuasive.

Contrary to the majority's analysis, the independent medical examining panels offer no proof that claimant's condition is not compensable. The first panel expressly attributed claimant's symptoms to the 1983 injury. The second also implicated claimant's work injuries in the development of her symptoms.

Therefore, because I find persuasive evidence showing causation and no contrary proof, I disagree with the majority that claimant failed to prove compensability.

In the Matter of the Compensation of
KAREN P. WAGNER, Claimant
WCB Case No. 93-04337
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for right C7 radiculopathy. Claimant moves for remand for admission of a post-hearing medical report. On review, the issues are remand and compensability. We deny the motion and affirm.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant argues that this case should be remanded for admission of a post-hearing medical report from Dr. Hill, a physician who had authored two reports that are already in the record. We disagree.

We may remand a case to the Referee for further evidence taking if we find that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, the moving party must establish, inter alia, that the evidence was not obtainable with due diligence at the time of hearing and that it was reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still be "obtainable" at the time of hearing. Id. at 648; James E. Gore, 45 Van Natta 1652 (1993).

In November 1992, claimant saw Dr. Hill at the request of her treating physician, Dr. Long. On November 19, 1992, Dr. Hill authored two reports regarding claimant's condition.[1] Those reports are in the record.

On June 10, 1993, prior to the June 30, 1993 scheduled hearing, claimant's attorney sent a letter to Dr. Hill, requesting that he render an opinion regarding the cause of claimant's current condition. (Affidavit of Claimant's Attorney at 1). The letter indicated that the hearing was to be held on June 30, 1993. (Id., Ex. B-1).

On June 14, 1993, Dr. Hill's office staff advised claimant's counsel that Dr. Hill would not be responding to the request for an opinion. (Id., Ex. C). Claimant's counsel called Dr. Hill's office staff, who said that Dr. Hill did not have the time to respond to inquiries regarding patients that he was not currently treating. (Id. at 1). Claimant's counsel attempted, without success, to convince Dr. Hill's staff to cooperate with her request for information. (Id.)

The hearing on SAIF's denial of claimant's C7 radiculopathy was held on June 30, 1993. Claimant did not mention an outstanding request for a medical report from Dr. Hill or request a continuance to keep the record open for the purpose of receiving a report from Dr. Hill.

On October 18, 1993, while claimant's request for Board review of the Referee's July 6, 1993 order was pending, Dr. Hill generated a report in response to a June 21, 1993 letter from SAIF regarding its medical examiners' report concerning the relationship between claimant's current condition and her

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[1] Dr. Hill's first report addresses claimant's physical condition; his second report requests authorization to perform surgery to alleviate claimant's radicular symptoms.

work activities. (Id., Ex. A). In the report, Dr. Hill stated that he did not concur with the medical examiners' report and that the major contributing cause of claimant current condition and her need for treatment in late 1992 was the changing circumstances in her work place.

We are not persuaded that Dr. Hill's supplemental opinion was unobtainable with the exercise of due diligence at the time of hearing. Claimant did not request that the record be left open for the purpose of obtaining Dr. Hill's opinion through some compulsory means, such as a deposition, a Referee order to require Dr. Hill to respond, or a subpoena for testimony. See Nighswonger's Contract Cutting, 45 Van Natta 1751 (1993). Thus, although Dr. Hill's post-hearing report was not available at the time of hearing, we are not convinced that the substance of that opinion was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., supra, 301 Or at 648; James E. Gore, supra.

Moreover, in light of the persuasive opinions offered by Dr. Amstutz, claimant's attending surgeon, and SAIF's medical examiners, we are not satisified that consideration of Dr. Hill's post-hearing opinion was reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., supra. For these reasons, we deny claimant's request for remand and proceed with our review.

Compensability

We adopt the Referee's conclusions of law and opinion with the following supplementation.

Dr. Long, claimant's treating physician, opined that, because claimant had no radicular symptoms for several months before the onset of her current condition in September 1992, the major contributing cause of that condition was her use of a new computer system at work, and not her preexisting degenerative disc disease. We agree with the Referee that that reasoning is faulty, inasmuch as it presumes that claimant's preexisting condition had somehow resolved before September 1992, and, therefore, could not have contributed to the onset of claimant's current condition.

The absence of radicular findings before September 1992 does not necessarily mean that claimant's preexisting degenerative disc condition had resolved; it could mean only that she was temporarily asymptomatic. At best, then, the lack of radicular findings for several months before September 1992 suggests a temporal relationship between claimant's use of her new computer system and the onset of her current C7 radiculopathy. Because such a relationship is, by itself, insufficient to satisfy claimant's burden, ORS 656.266, Ruben G. Rothe, 45 Van Natta 369 (1993), we afford Dr. Long's reports little probative weight, and affirm the Referee's conclusion that claimant has not established that her work was the major cause of her current condition.

In adopting the Referee's conclusion, we share the Referee's reasoning that the opinion offered by SAIF's medical examiners is persuasive. We find as further support for the Referee's conclusion the opinions of claimant's surgeon, Dr. Amstutz, who performed a posterior cervical laminectomy on claimant in January 1993.

In a letter to claimant's counsel, Dr. Amstutz opined that he thought that claimant's problems were a result of the degenerative changes in her spine. (Ex. 13A). Dr. Amstutz also signed a letter drafted by SAIF's adjuster that stated that Dr. Amstutz concurred with SAIF's medical examiners' report, which concluded that the major contributing cause of claimant's current disability and need for treatment was her degenerative spinal condition. (Ex. 16). Because Dr. Amstutz's opinions are unrebutted by any persuasive evidence regarding impact of claimant's preexisting condition on her current condition, and because Dr. Amstutz was claimant's surgeon, we conclude that his opinions are probative of the noncompensability of claimant's current condition. See Jerry B. Mathel, 44 Van Natta 1113, on recon 44 Van Natta 1532 (1992), aff'd Mathel v. Josephine Co., 122 Or App 424 (1993); see also Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

ORDER

The Referee's order dated July 6, 1993 is affirmed.

In the Matter of the Compensation of
KARSON REUBEN-BIGBOY, Claimant
Own Motion No. 93-0555M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

The SAIF Corporation initially advised the Board that claimant requested reopening of her claim for proposed surgery on her left knee as recommended by Dr. Loch. As Dr. Loch is not a member of SAIF's managed care organization, SAIF contested the surgery request. Subsequently, claimant began treating with Dr. Grewe, a member of SAIF's managed care organization.

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.

There is no request for surgery from Dr. Grewe in the record. Therefore, we are unable to authorize reopening of claimant's claim, as no surgery of hospitalization has been requested.

We conclude the request for own motion relief can be dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY L. CONOVER, Claimant
WCB Case No. 91-04236
ORDER ON REMAND
Whitehead & Klosterman, Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is on remand from the Court of Appeals. Conover v. K-Mart Corporation, 123 Or App 435 (1993). The court has reversed our order which affirmed a Referee's dismissal for lack of jurisdiction of claimant's hearing request concerning the reasonableness and necessity of medical services. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant compensably injured his low back on November 21, 1990. On November 26, 1990, claimant sought treatment from a chiropractor, Dr. Lawton, who referred claimant to Northwood Rehabilitation Center (Northwood) for testing that took place on December 3 and 26, 1990. The self-insured employer was billed $906 for the testing. Dr. Stringham, M.D., became claimant's treating physician on January 3, 1991.

On March 6, 1991, the employer denied payment of the Northwood billing on the grounds that the services were not reasonable and necessary and that Dr. Lawton was not an "attending physician." Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing for lack of jurisdiction, citing Stanley Meyers, 43 Van Natta 2643 (1991). We affirmed and adopted the Referee's order on November 25, 1992. Claimant then requested judicial review.

Meanwhile, claimant had sought Director's review to determine whether the Northwood testing was appropriate. On July 16, 1991 (subsequent to the Referee's dismissal order), the Director issued an order finding that the testing was not appropriate and that the employer was not required to reimburse Northwood for its evaluation of claimant. Claimant sought review of the Director's order before the Hearings Division. On December 14, 1992, a referee affirmed the Director's order under a "substantial evidence" standard of review. See ORS 656.327(1)(b). Claimant did not appeal the Referee's order.

Citing Meyers v. Darigold, Inc., supra, the court has now reversed our November 25, 1992 order and remanded for reconsideration. Conover v. K-Mart Corporation, supra. Prior to proceeding with our reconsideration, we allowed the parties to submit supplemental briefs addressing the matters at issue, i.e., the effect of the final litigation order under ORS 656.327(2), and whether the disputed medical service billing was appropriate. See OAR 438-11-020(2). Having received those briefs, we proceed with our reconsideration.

The employer contends that claimant should be precluded from relitigating the issue of the appropriateness of the Northwood testing because claimant has already unsuccessfully sought Director's review of the issue and the Referee issued a final, unappealed order affirming the Director's order. The issue, therefore, is whether the Referee's order decided under a "substantial evidence" standard precludes subsequent litigation of the same issue under a "preponderance of the evidence" standard. Resolution of this issue depends on application of the doctrine of res judicata.

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 District v. White, 305 Or 48, 53, mod 305 Or 468 (1988). Claim preclusion 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 at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). There must also be an opportunity to litigate the claim, whether or not used, and there must be a final judgement. Id.

Here, there was "actual litigation" concerning the reasonableness and necessity of the disputed medical services. In other words, the parties availed themselves of the opportunity to present their respective positions to the Director regarding the propriety of the Northwood billing. See ORS 656.327. Moreover, following the Director's decision, claimant sought review before the Hearings Division. ORS 656.327(2). We, therefore, conclude that issue preclusion is applicable.

The current litigation involves the same parties that participated in the prior litigation on the same issue, i.e., the reasonableness and necessity of claimant's evaluation at Northwood. In addition, the determination of this issue was essential to the outcome of the the prior decision affirming the Director's order. Accordingly, we find that issue preclusion bars claimant from relitigating the same issue previously litigated before the Director and the Hearings Division. North Clackamas School District v. White, supra.

Claimant contends, however, that the Referee's order affirming the Director's order was based on a "substantial evidence" standard of review; whereas now he would be entitled to a "de novo" review involving a "preponderance of the evidence" test. Claimant further argues that the Director's and the Referee's orders are not part of the record in this case and that, even if they can be considered in these proceedings, their effect is only "jurisdictional." We disagree.

We may 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); Efrain C. Espinoza, 45 Van Natta 348, 349 (1993). This includes the orders of other state agencies. See Shannon K. Hartshorn, 45 Van Natta 1243, 1245 (1993). Accordingly, we can take official notice of the Referee's as well as the Director's order.

Moreover, the effect of these decisions are more than jurisdictional. They determined the very issue claimant now wishes to relitigate, that is, the reasonableness and necessity of the Northwood evaluation. Claimant cannot relitigate the same issue. North Clackamas School District v. White, supra.

Finally, the Director's review was not for "substantial evidence." Claimant had the opportunity to present any evidence he deemed relevant to the disputed medical services issue. The fact that a Referee subsequently reviewed the Director's determination for substantial evidence did not prevent claimant from appealing the Referee's order while the jurisdictional issue was being resolved in separate proceedings. Neither was claimant precluded from requesting a postponement of the hearing on the medical services issue pending the outcome of the jurisdictional appeal. For these reasons, we find that claimant is precluded from relitigating the medical services issue.[1]

Alternatively, even if this claim was not barred by issue preclusion, we would still find that the disputed medical services are not compensable on the merits. Assuming without deciding that Dr. Lawton was an attending physician and, therefore, able to authorize the disputed medical services, we are not persuaded that the Northwood evaluation was reasonable and necessary.

Both claimant and the employer cite Tina M. Lingar, 41 Van Natta 420 (1989), as providing the appropriate legal test for determining whether medical services are "reasonable and necessary." Lingar holds that medical services must likely be of "significant curative, palliative, preventative or restorative benefit." 41 Van Natta at 425.

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[1] We are mindful that claimant requested Director's review after his initial request for hearing was dismissed for lack of jurisdiction. Given the court's holding in Meyers, jurisdiction has always resided in the Hearings Division. Nevertheless, this does not alter our conclusion that issue preclusion prevents claimant from relitigating the reasonable and necessary issue. Again, the same parties actually litigated the same issue before the Director. Claimant had the opportunity to continue this litigation with ensuing appellate review of this same medical services dispute. However, he neither appealed the Referee's order affirming the Director's order nor sought a postponement of further proceedings pending resolution of the jurisdictional litigation. Inasmuch as the Director's review involved the same parties and their actual litigation of the same issue present in this case, and because the Referee's order affirming the Director's decision has become final, we hold that the parties are precluded from relitigating this medical services issue.

Here, Dr. Lawton described the purpose of the Northwood referral as being for "objective verification" and "objective substantiation" of injury. (Ex. 32). We agree with the employer that the purpose of the Northwood testing was only to verify objective evidence of injury and that the testing was not performed for any significant curative, palliative, preventative or restorative benefit. Tina M. Lingar, supra.

The medical opinions of the other physicians involved in the claim also support our conclusion. Dr. Stringham wrote: " I can simply say that I have never ordered those tests and have not found the data produced from those tests particularly useful to me when provided from other sources in my management of patients." (Ex. 23-2). Dr. Brown, an examining physician, opined that the computerized testing at Northwood was neither "practical nor necessary." (Ex. 16). He further commented: "I am not opposed to advances in medicine but when it comes to the back, precise degrees of rotation, lateral bending, and forward flexion are of no significance." (Ex. 16).

In light of such circumstances, we are not persuaded that the disputed testing is reasonable and necessary treatment. Consequently, we would not find the employer responsible for the Northwood bill. Accordingly, on reconsideration of our November 25, 1992 order, we hold that resolution of this dispute is controlled by the Director's order as affirmed by the subsequent referee's order. Alternatively, were we required to reach the merits, we would uphold the employer's March 6, 1991 denial of claimant's medical services claim.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHELLEY C. NIKOLAUS, Claimant
WCB Case Nos. 92-13740 & 92-13114
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Daryll E. Klein, Defense Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband, and Haynes.

Claimant and Mid-Century Insurance Company (Mid-Century) request review of Arbitrator McWilliams' order that: (1) set aside Mid-Century's denial of responsibility for claimant's new injury claim for her right neck, upper back and shoulder; and (2) upheld SAFECO Insurance Company's (SAFECO) denial of responsibility for claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant worked as an automobile mechanic for Auto Wrench, Inc., SAFECO's insured. Her weekly wage was $476. She compensably injured her right neck, upper back, and shoulder when she caught a falling transmission in January 1990. She was diagnosed with a right upper extremity overuse syndrome. She was declared medically stationary on August 19, 1991 and released to work as a mechanic with limitations which precluded lifting and carrying over 65 pounds and use of the arm in any overhead fashion.

The claim was closed with an award of 8 percent unscheduled permanent disability for the right shoulder and neck. This award was increased to 10 percent by a Settlement Stipulation.

In March 1992, claimant began working at Jerry's Automotive, Mid-Century's insured, performing tune-ups, brake work and occasional transmission installations. Her weekly wage was $275.88. Her hours increased to ten per day, and her tasks required increasing amounts of overhead work for prolonged periods. Claimant developed pain in her right shoulder which gradually increased until about June 15, 1992. On that day, her pain sharply intensified following prolonged overhead transmission work. Claimant was unable to alleviate her pain with her usual self-treatment. She quit her job that day because she believed the job duties were no longer within her physical capabilities. Claimant sought treatment on July 1, 1992 for aching and sharp shooting pain over the right shoulder girdle and upper arm, tightness in the left upper back, headaches, and hand swelling. (Tr. 21, 22 and 24).

On September 11, 1992, SAFECO denied responsibility. On October 15, 1992, Mid-Century denied responsibility. On March 5, 1993, an order issued pursuant to ORS 656.307, designating Mid-Century as the paying agent pending the outcome of the arbitration proceeding.

Based on claimant's weekly wages at time of the injury, the temporary total disability rates would be $362.67, if SAFECO is found to be the responsible insurer, or $190.28, if Mid-Century is found to be the responsible insurer.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

Claimant and Mid-Century seek review of the Arbitrator's decision assigning responsibility to Mid-Century. ORS 656.307(2) provides that we review decisions rendered by an arbitrator for questions of law except in one circumstance: "[I]f the claimant can establish, on the arbitration record, that the determination [of the responsibility issue] resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board * * * shall be as provided for matters concerning a claim." ORS 656.704(3) defines a matter 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 previously concluded that the Legislature intended, by the exception, to give a claimant the benefit of de novo review when a claimant contends that the arbitrator erred and a different assignment of responsibility will affect the rate of temporary disability compensation. John L. Riggs, III, 42 Van Natta 2816, 2817 (1990); Jon E. Robinson, 42 Van Natta 512 (1990).

Here, claimant requested review and contends that the Arbitrator erred in the assignment of responsibility to Mid-Century. The arbitration record indicates that claimant's rate of temporary total disability will be substantially greater if responsibility were to be assigned to SAFECO. Accordingly, because the assignment of responsibility will affect the rate of temporary disability compensation, we review de novo.

Responsibility

Relying on the Board's decision in Rosalie S. Drews, 44 Van Natta 36 (1992), the Referee concluded that claimant had experienced a new injury, involving the same condition, at Mid-Century's insured, on the basis that her work there was a material contributing cause of her disability and need for treatment. Therefore, the Referee concluded that responsibility shifted from SAFECO to Mid-Century, pursuant to ORS 656.308(1).

Subsequent to the Referee's order, the Supreme Court held in SAIF v. Drews, 318 Or 1 (1993), that the major contributing cause standard of ORS 656.005(7)(a)(B) applies to responsibility determinations under ORS 656.308(1). Thus, if an accidental injury at a subsequent employment combines with a preexisting condition for which a prior employer is responsible, responsibility for future compensable medical services and disability shifts to the subsequent employer if the new injury is found to be "the major contributing cause of the disability or need for treatment." SAIF v. Drews, supra.

Claimant and Mid-Century contend that claimant's current condition is an aggravation of her 1990 injury, and not the result of a new compensable injury at Mid-Century's insured. We disagree.

The causation of claimant's current condition 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). Accordingly, we review the medical evidence in the record.

Claimant's 1990 compensable injury resulted in permanent impairment in the neck, upper back, and right shoulder. For that impairment, claimant received 10 percent unscheduled permanent disability benefits. That award was based on findings that claimant was unable to perform work involving overhead use of her right arm; that she has a permanently chronic condition limiting repetitive use; and that her condition may be subject to waxing and waning of symptoms in the future. (Ex. 21A-2). Claimant testified that, following closure of the 1990 claim, she continued to have soreness in the right shoulder most of the time. (Tr. 8).

Notwithstanding her permanent restrictions, claimant got a job as an auto mechanic with Mid-Century's insured in March 1992. At first, the job involved little overhead use of the right arm. (Tr. 11). As she continued to work, however, claimant began performing more overhead work for long periods of time, resulting in gradually increasing shoulder pain. (Ex. 22-1). She initially self-treated with ice and heat, exercise, and a TENS unit.

On or about June 15, 1992, claimant had a flare-up of shoulder pain following prolonged overhead transmission work. She was unable to alleviate her discomfort with her usual self-treatment regimen. On July 1, 1992, she sought treatment for constant aching, burning pain, with occasional sharp, shooting pain over the right shoulder girdle into the shoulder and upper arm, tightness in the left upper back, headaches, and a numbing sensation from the shoulder to the mid-forearm. Dr. MacRitchie, claimant's attending physician, opined that claimant's then-current condition was in the same area and of the same type as claimant's condition prior to closure of the 1990 claim, but that the symptoms were more severe. (Exs. 32-10, 32-11). Dr. MacRitchie considered claimant's condition in 1992 to be an "exacerbation" of the same condition for which claimant had been treating in 1990 and 1991. (Ex. 32-23).

Based on Dr. MacRitchie's opinion, we find that claimant's condition following the 1990 injury was a preexisting condition which combined with the 1992 incident to cause claimant's disability and need for treatment. Therefore, in order to shift responsibility for a "new injury" to Mid-Century's insured, we must find that the 1992 incident was the major contributing cause of claimant's resultant condition. See ORS 656.005(7)(a)(B), 656.308(1); SAIF v. Drews, supra.

Dr. MacRitchie opined that, if claimant was required to work beyond her physical restrictions at Mid-Century's insured, then that employment (in 1992) was the major contributing cause of her current condition. (Ex. 23). Dr. MacRitchie stated that the day of overhead transmission work in 1992 brought about claimant's severe, acute symptoms. (Ex. 32-18). Dr. MacRitchie also indicated that claimant's acute symptomatic flare-up following the 1992 work incident was more severe than what she had anticipated at the time the 1990 claim was closed. (Id). She added that the June 1992 incident increased claimant's susceptibility to reinjury of the right shoulder. (Ex. 32-17).

Dr. Woolpert, examining physician, found that claimant exceeded her work restrictions in her 1992 employment, particularly during the June 1992 incident, and that claimant's symptoms are greater than they were prior to that employment. He opined, therefore, that "the work at [Mid-Century's insured] is the reason [claimant] required further treatment and further disability beginning in June of 1992." (Ex. 30-5). Although Dr. Woolpert later characterized the 1992 incident as a "material" cause of claimant's need for treatment, we conclude that his report as a whole (particularly considering his earlier conclusions that claimant's Mid-Century work was the reason for claimant's current need for treatment) supports the finding that the June 1992 injury is the major contributing cause of claimant's need for treatment. In reaching this conclusion, we note that no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

The opinions of Drs. MacRitchie and Woolpert are unrebutted. Both doctors attributed claimant's worsening symptoms not just to the 1992 employment, but to a discrete, identifiable incident in June 1992 when claimant performed prolonged overhead transmission work. Although neither doctor could say whether claimant's underlying condition was pathologically worsened by the 1992 incident, Dr. MacRitchie opined that the incident made claimant's right shoulder condition more susceptible to reinjury. Given this medical record, we find that the June 1992 work incident with Mid-Century's insured was the major cause of claimant's subsequent disability and need for treatment. Accordingly, responsibility shifts to Mid-Century. See ORS 656.308(1); SAIF v. Drews, supra.

ORDER

The Referee's order dated April 16, 1993 is affirmed.

Board Member Haynes dissenting.

The majority holds that review of the Arbitrator's decision should be de novo, based on their findings that claimant requested review and the arbitration record indicates that her rate of temporary total disability will be greater if responsibility were to be assigned to SAFECO. Because I disagree with their legal analysis, I respectfully dissent.

Here, the sole argument claimant raised at hearing and on review is that she did not experience a new injury at Mid-Century's insured. Although SAFECO cross-examined claimant on her wage rates at hearing (Tr. 14) and submitted into the record a copy of the ".307" order that notified claimant of the difference in temporary total disability rates, claimant has neither contended that the Arbitrator's determination resolves a matter concerning a claim, nor that her time loss benefits would be greater if SAFECO were found to be the responsible insurer. Furthermore, the Arbitrator made no findings regarding the matter. Generally, the Board does not consider for the first time on review a theory that was not raised at hearing. See Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993). Accordingly, I would review the Arbitrator's order solely for questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

Where an Arbitrator's order is not consistent with applicable law, the Board remands for the proper application of law. See Yolanda Carrasco, 42 Van Natta 2289 (1990). Consequently, because the Arbitrator's order is not consistent with applicable law, see SAIF v. Drews, supra, I would vacate the order and remand for the proper application of law. Yolanda Carrasco, supra.

March 21, 1994 Cite as 46 Van Natta 461 (1994)

In the Matter of the Compensation of
OLGA I. SOTO, Claimant
WCB Case No. 91-12369
ORDER ON REMAND (REMANDING)
Michael B. Dye, Claimant Attorney
John T. Bagg (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Soto v. SAIF, 123 Or App 358 (1993). The court has reversed our prior order, Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992), which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Citing Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact, as supplemented in our April 7, 1992 Order on Review, with the following correction. The Determination Order issued January 17, 1991, not February 5, 1991. (Ex. 10).

CONCLUSIONS OF LAW AND OPINION

A January 17, 1991 Determination Order closed claimant's right wrist, arm, shoulder and buttocks injury claim with no award of permanent disability. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The August 29, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Determination Order in all respects. In addition, the Order on Reconsideration recognized that claimant was entitled to an examination by a medical arbiter and indicated that the Appellate Unit would schedule the claim for a medical arbiter review pursuant to ORS 656.268(7). (Ex. 13-1). Claimant requested a hearing.

The Referee found the Order on Reconsideration invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order.

In our prior order, we affirmed the Referee's order dismissing claimant's request for hearing for lack of jurisdiction. Olga I. Soto.

In Pacheco-Gonzalez v. SAIF, supra, the court reversed the reasoning we used in deciding Olga I. Soto, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for

reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Here, relying on its decision in Pacheco-Gonzalez v. SAIF, supra, the court has remanded our prior order for reconsideration. Accordingly, we proceed with our reconsideration.

At hearing, a medical arbiter's report, based on an October 15, 1991 examination by orthopedist Dr. Stanford, was submitted for the record. (Ex. 14). However, this exhibit was excluded by the Referee on the ground that the medical arbiter's report was made after the Order on Reconsideration. Thereafter, the Referee dismissed claimant's hearing request without taking testimony.

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. ORS 656.295(5). Under the circumstances of this case, we find the record insufficiently developed. Moreover, in light of the court's recent decision in Pacheco-Gonzalez v. SAIF, supra, we find a compelling reason to remand. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993). Consequently, we remand this matter to the Referee for further evidence taking. See Carl R. Alatalo, 46 Van Natta 338 (1994) (Any issues concerning "post-medical arbiter report" evidence shall be addressed by referee on remand in light of Pacheco-Gonzalez and Gary C. Fischer, 46 Van Natta 60 (1994), on recon 46 Van Natta 221 (1994).

Accordingly, the Referee's November 29, 1991 order, as amended December 6, 1991, is vacated. Since the Referee who initially heard this case is no longer employed by the Board, we remand to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall conduct further proceedings in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7). Once these further proceedings are completed, the assigned Referee shall issue a final appealable order.

IT IS SO ORDERED.

March 22, 1994 Cite as 46 Van Natta 462 (1994)

In the Matter of the Compensation of
CHARLES E. MUNGER, Claimant
WCB Case No. 92-07308
ORDER ON REMAND
Malagon, et al, Claimant Attorneys
Neil W. Jones, Defense Attorney

Reviewed by the Board en banc.

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 24, 1994 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders. Specifically, claimant agrees that the insurer's denial "shall remain in full force and effect." Furthermore, the parties stipulate that this matter shall be dismissed with prejudice.

Finally, the settlement provides that claimant's attending physician shall receive $9,915 of the $43,915 settlement proceeds. In consenting to and authorizing such a payment, claimant expressly acknowledges that such an allocation of funds "is an amount in excess of the minimum required by ORS 656.313."[1]

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[1] The proposed settlement also does not include a list of medical service providers who shall receive reimbursement and the amounts of such reimbursement. See OAR 438-09-010(2)(g). However, this apparent omission is explained in the agreement, which provides that "[o]n and before the date of the settlement, [the insurer] had received no other billings from medical service providers." In light of this explanation, we conclude that the aforementioned "list" requirement has been satisfied.

This provision raises the question as to whether it is permissable for a worker to agree to pay a portion of the worker's funds from a disputed claim settlement (DCS) to a medical service provider in excess of the reimbursement formula prescribed in ORS 656.313(4)(d). We conclude that such a provision is acceptable, provided that the worker expressly acknowledges that the proposed reimbursement exceeds the requirements prescribed in ORS 656.313(4)(d). We base our conclusion on the following reasoning.

Pursuant to ORS 656.313(4)(d), reimbursement from DCS proceeds to medical service providers shall be made at one-half the amount provided under ORS 656.248. Subject to one exception, ORS 656.313(4)(d) limits the total reimbursement to medical service providers to 20 percent of the total present value of the DCS. Id. That exception is if the worker consents to a reimbursement distribution in excess of the 20 percent scheme. Id.

Since the first sentence in ORS 656.313(4)(d) states that the provider's reimbursement shall be "made at one-half the amount provided under ORS 656.248," it would appear that a provider's total DCS "reimbursement" under ORS 656.313 is limited to 50 percent of its recovery under the Department's rules. Nevertheless, if the worker is expressly acknowledging in the DCS that the proposed distribution is in excess of the statutory scheme, we interpret such a provision as essentially the worker's assignment of personal funds which were not subject to the "reimbursement" provisions of ORS 656.313.

Inasmuch as DCS proceeds are not compensation, they are not subject to the prohibition against assignments in ORS 656.234. Catarino Garcia, 40 Van Natta 1846 (1988); Theodule LeJeune, Jr., 40 Van Natta 493 (1988). Therefore, as long as it is apparent from the DCS provisions that claimant is knowingly consenting to a payment to his / her medical service provider in an amount beyond the statutory "reimbursement" scheme, such a DCS is approvable.

In reaching this conclusion, we wish to emphasize that a claimant is under no statutory obligation to pay a medical service provider in excess of the reimbursement formula prescribed in ORS 656.313(4)(d). Moreover, our approval should not be interpreted as an opportunity to allow medical service providers to interfere with settlement negotiations or put any pressure on claimants to consent to payment arrangements in excess of the statutory "reimbursement" scheme. However, if a claimant wishes to forward additional funds to a provider in excess of that "reimbursement" formula and, in doing so, expressly represents that such an action was taken with full knowledge of his / her statutory rights, we shall honor the claimant's wishes.

Based on the aforementioned reasoning, we have approved the parties' agreement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

March 23, 1994 Cite as 46 Van Natta 463 (1994)

In the Matter of the Compensation of
DENA G. ELDRIDGE, Claimant
WCB Case Nos. 92-13089 & 93-02398
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The insurer requests review of that portion of Referee Livesley's order which set aside its denials of claimant's injury/occupational disease claims for a degenerative cervical condition. Claimant cross-requests review of that portion of the Referee's order which awarded claimant's attorney an assessed fee of $2,550 for prevailing against the insurer's denials. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "findings of fact" with the following supplementation.

Claimant, a certified nursing assistant (CNA), filed a claim for a "strain back-neck" that occurred on April 1, 1990. On June 11, 1990, the claim was accepted on the form 801 as a nondisabling injury. Prior to that time, Dr. Bamforth, a chiropractor, diagnosed a thoraco-lumbar and thoraco-cervical sprain/strain. (Ex. 2).

Claimant subsequently consulted a family practitioner, Dr. Beckwith, who also diagnosed a neck and back sprain. (Ex. 3). This diagnosis was later modified in November 1990, to include a chronic pain syndrome and fibrositis syndrome. The claim was closed by February 14, 1991 Notice of Closure, which did not award any permanent disability.

A May 1992 MRI revealed degenerative changes at C5-6, but no discrete disc extrusion. At this time, claimant had been referred to a neurosurgeon, Dr. McGirr, who opined that claimant had no surgical lesion. He recommended conservative treatment for claimant's cervical strain.

In August 1992, claimant filed an aggravation claim for her cervical condition. It was denied on October 1, 1992 on the grounds of no worsening of claimant's cervical condition since the February 14, 1991 Notice of Closure.

In November 1992, an orthopedist, Dr. Bert, became claimant's treating physician. Dr. Bert interpreted x-rays as showing cervical spondylosis at C5-6, for which he recommended a cervical discectomy and fusion. Claimant's "claim" was denied on February 13, 1993.

At hearing, the insurer's denials were amended, and the issues were framed as the compensability of claimant's cervical spondylosis at C5-6, either as an injury or as an occupational disease, and the compensability of claimant's aggravation claim.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant's cervical spondylosis was compensable, citing Georgia Pacific v. Piwowar, 305 Or 494 (1988). Specifically, the Referee found that, when the insurer accepted claimant's April 1990 back and neck claim on the form 801, it accepted a symptom (neck stiffness) of claimant's underlying cervical spondylosis condition. Therefore, under Piwowar, the Referee reasoned that the insurer could not deny responsibility for the subsequently discovered cause of claimant's cervical condition.

Where an insurer accepts a symptom of a disease, it also accepts the disease causing the symptom. Georgia-Pacific v. Piwowar, supra. The Referee determined that the insurer was precluded from denying claimant's cervical spondylosis because it accepted a symptom of the cervical spondylosis condition and was, therefore, responsible for the underlying cause of the symptom under Piwowar. We disagree.

Whether acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In Box 16 of the form 801, which requires claimant to list the nature of the injury or disease, she wrote "strain back-neck." In Box 17, in which claimant is asked to describe the industrial accident, she wrote that, since her accident, her "back and neck have been getting stiffer." The Referee held that, when it accepted the claim on the form 801, the insurer accepted a "back strain," but did not accept a "neck strain." According to the Referee, the insurer accepted only a stiff neck, which was merely a symptom of the subsequently diagnosed cervical spondylosis. We disagree with the Referee's factual analysis.

We interpret Box 16 as meaning that claimant intended to report both a back and a neck strain. The initial diagnoses by Drs. Bamforth and Beckwith are further evidence that the insurer was presented with a claim for cervical sprain/strain rather than for a "stiff neck." (Exs. 2, 3). Since there is no evidence that a neck strain is a symptom of the underlying cervical spondylosis, we find that the insurer's acceptance was limited to a "neck strain." See Patty A. Durr, 45 Van Natta 940 (1993) (carrier did not accept symptoms of fibromyalgia when it accepted arm and hand strain when medical evidence did not demonstrate that arm and hand strain was a symptom of fibromyalgia). The insurer did not become responsible for the underlying cervical spondylosis when it accepted the cervical claim on the form 801.

Despite our determination that Piwowar is not factually applicable, treatment for claimant's cervical spondylosis is still compensable. We base this conclusion on the following reasons.

The insurer denied the compensability of claimant's cervical spondylosis on either an injury or an occupational disease theory. Dr. McGirr opined that claimant's spondylosis preexisted her accidental injury in 1990. (Ex. 44). Dr. Woolpert, an examining physician, agreed. (Ex. 48). Dr. Bert also stated that the spondylosis preexisted the 1990 injury. (Ex. 44A). Given these medical opinions, we find that claimant's cervical spondylosis preexisted the 1990 injury.

Claimant must prove that her work activities were the major contributing cause of a worsening of the preexisting condition to establish a compensable occupational disease. See ORS 656.802(2); Aetna Casualty v. Aschbacher, 107 Or App 494 (1991). Alternatively, on the accidental injury theory, if we find that claimant's compensable cervical strain combined with the preexisting cervical spondylosis to cause a need for medical treatment, for the current "resultant condition" to be compensable, claimant must prove that the compensable 1990 cervical injury is and remains "the major contributing cause" of her current disability and need for medical treatment under ORS 656.005(7)(a)(B). See Tektronix v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993).

In either case, we find the causation issue to be medically complex. Accordingly, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Bert, claimant's current attending physician, has opined that claimant's 1990 injury combined with her preexisting cervical spondylosis and that the compensable injury is the major contributing cause of her need for medical treatment. (Exs. 44A, 49). Moreover, Dr. Bert also confirmed that work activities during the course of her employment for this employer worsened or accelerated the preexisting spondylosis. (Ex. 49).

Dr. Bert explained that claimant was asymptomatic prior to the 1990 injury and that claimant's injury rendered the preexisting cervical spondylosis symptomatic. Indicating that he was aware of the work duties of a CNA, Dr. Bert stated that a nursing assistant can sometimes take a sudden load to the spine when a patient collapses, as happened in this case. In the absence of any other history of injuries, Dr. Bert concluded that claimant's employment is the major factor in her present disability. (Ex. 50).

When the medical evidence is divided, we tend to give the greatest weight to the opinion of the treating doctor, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). We find that there are no such reasons in this case.

Dr. McGirr opined that claimant's 1990 cervical strain was not the major contributing cause of the C5-6 spondylosis, but this opinion was conclusory and given in a "check-the-box" manner. (Ex. 51). It is therefore entitled to little weight. See David J. Rowley, 45 Van Natta 1659 (1993). Moreover, Dr. McGirr does not address the issue of whether claimant's injury remains the major contributing cause of claimant's need for medical treatment, nor does he offer an opinion on whether claimant's injury or employment worsened or accelerated the cervical spondylosis. (Ex. 51).

Dr. Woolpert concluded that claimant's current need for treatment is due to the preexisting cervical spondylosis. (Ex. 48). Although this opinion contained a thorough analysis of the causation issue, we consider it insufficient to overcome the weight accorded the attending physician's opinion for the following reasons. Dr. Woolpert conceded that he did not have all of Dr. Bert's medical records when he rendered his opinion. (Ex. 48-3). Moreover, Dr. Woolpert does not adequately address the reasoning posed by Dr. Bert as to why someone as young as claimant would have the extensive

Finally, claimant contends that she is entitled to an increased assessed attorney fee for her counsel's efforts in establishing the compensability of her cervical spondylosis. We disagree.

After considering all the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's attorney's services at hearing regarding the cervical spondylosis condition is $2,550. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the benefit secured for claimant and the risk that claimant's counsel might go uncompensated.

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. Finally, claimant is not entitled to an attorney fee award for services on review concerning the Referee's attorney fee award. Dotson v Bohemia, Inc, 80 Or App 233 (1986).

ORDER

The Referee's order dated June 29, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the insurer.

March 23, 1994 Cite as 46 Van Natta 466 (1994)

In the Matter of the Compensation of
MARIA GONZALES, Claimant
WCB Case Nos. 93-04510, 92-15776 & 93-01018
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer, National Cleaning, requests review of Referee Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral wrist and elbow conditions; and (2) upheld the SAIF Corporation's denial, on behalf of N & C Service Co., and the Fireman's Fund Insurance Company's denial, on behalf of Commercial Building Maintenance, of the same conditions. On review, the issues are compensability and responsibility.

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

Compensability

The Referee found that claimant's bilateral wrist and elbow conditions (diagnosed as bilateral carpal tunnel syndrome and bilateral epicondylitis, respectively) are compensable. We agree, based on the opinion of Dr. Layman, treating physician, who stated that claimant's "

Moreover, the fact that a medical opinion is apparently based on incomplete facts does not necessarily render the opinion unpersuasive, unless the omitted facts "have some bearing on the relevant issue." Palmer v. SAIF, 78 Or App 151 (1986). On this record, we cannot say that claimant's "omitted" 1986 history has bearing on the causation issue, based on the following reasoning.

The only evidence arguably casting doubt on the persuasiveness of Dr. Layman's conclusion regarding causation is the opinion of Dr. Button, who examined claimant once. Dr. Button initially related claimant's symptoms to her work activities. (Ex. 23). Later, upon learning that claimant had similar right hand symptoms in 1986, Dr. Button withdrew his opinion concerning causation because he suspected that claimant had been untruthful with him. (Ex. 24). Dr. Button did not explain why the existence of prior symptoms affected his reasoning or how it rendered him unable to evaluate causation, beyond stating that he could no longer "separate truth from fiction." (Id). Moreover, as we have stated, we find claimant's lack of memory concerning the 1986 problems entirely consistent with her lack of treatment for six years and her failure to report the 1986 history.

Under these circumstances, we are not persuaded that claimant was "untruthful" to either physician and we find no evidence that knowledge of the 1986 history (and the absence of treatment between 1986 and 1992) would have impacted Dr. Layman's opinion. Consequently, we are not persuaded that the omitted historical facts bear on the causation issue and we find no persuasive reason to discount the opinion of Dr. Layman, treating physician.

Accordingly, based on Dr. Layman's opinion, we agree with the Referee that claimant has established that her work activities for National Cleaning were the major contributing cause of her bilateral wrist and elbow conditions. Thus, the claim is compensable.

Responsibility

We have held that the last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. Where actual causation is established with respect to a specific employer, the last injurious exposure rule is not applied. Eva R. Billings, 45 Van Natta 2142 (1993).

Here, the persuasive evidence proves that claimant's work activities for National Cleaning caused her upper extremity diseases. There is no evidence that other work or off-work exposures contributed. Under these circumstances, claimant has proven that her work exposure with National Cleaning actually caused the conditions claimed and National Cleaning is responsible for the claim.

Alternatively, assuming that the last injurious exposure rule does apply, we would reach the same result. We would assign responsibility to National Cleaning, as it is the employer for whom claimant worked when she first sought and received medical treatment for her compensable (i.e., work-related) conditions. See Timm v. Maley, 125 Or App 396, 401 (1993). Under these circumstances (and assuming that claimant has not proven actual causation), we would assign responsibility to National Cleaning in the first instance, because claimant first sought treatment for the compensable condition while employed there.[1]

Finally, because National Cleaning has not established that prior work conditions were the sole cause of claimant's wrist and elbow conditions or that it was impossible for its work conditons to cause these conditions, responsibility remains with National Cleaning. See FMC Corporation v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

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[1] Even though claimant did seek treatment in 1986 (for a condition tentatively diagnosed as right CTS), there is no evidence that the 1986 condition was work-related. Therefore, we cannot say that claimant's treatment in 1986 was "for the compensable condition." See Timm v. Maley, supra. Moreover, even if claimant sought treatment "for the compensable condition" in 1986 (when SAIF was on the risk) and 1986 was treated as the disability date, we would conclude that responsibility shifts to National Cleaning, because claimant's work activities during the latter exposure independently contributed to the cause or worsening of her compensable conditions. See Catherine D. Townsend, 46 Van Natta 27 (1994).

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 $1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 27, 1993 is affirmed. For services on review, claimant's counsel is awarded a $1,200 attorney fee, payable by National Cleaning.

In the Matter of the Compensation of
GAYLYNN GRANT, Claimant
WCB Case No. 93-03010
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's partial denial of a left elbow ulnar nerve lesion. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to prove that her left ulnar nerve lesion was compensable for two reasons. First, the Referee found that the medical evidence did not support a finding that the ulnar nerve lesion was a result of claimant's compensable injury. Second, citing Kephart v. Green River Lumber, 118 Or App 76 (1993), the Referee concluded that an injury that occurs during vocational training is not considered a compensable consequence of the original compensable injury. We disagree with both conclusions.

First, we clarify our understanding of Kephart. In Kephart, a worker compensably injured his hand. While participating in an authorized training program, he injured his shoulder. The court explained that an injury that occurs during vocational training is no longer compensable simply because it occurred during vocational training, but is now subject to ORS 656.005(7)(a)(A), if it is not directly related to the industrial accident. It concluded that, because the worker's shoulder injury was not directly related to the accident to claimant's hand, but was a consequence of the industrial injury which had necessitated vocational rehabilitation, it would be compensable only if the compensable injury was the major contributing cause pursuant to ORS 656.005(7)(a)(A). See Kephart, supra, 118 Or App at 79; see also Edward J. Nicks, 45 Van Natta 1613 (1993). However, we interpret the Kephart court as holding that ORS 656.005(7)(a)(A) does not apply where the evidence indicates that a condition is directly related to the compensable injury, but was not diagnosed until some time later, even if the worker was taking part in a vocational program at the time of diagnosis. See Kephart, supra, 118 Or App at 79 (citing Albany General Hospital v. Gasperino, 113 Or App 411 (1992)).

Accordingly, we first look at the medical evidence to establish whether claimant's left ulnar nerve lesion is directly related to the industrial accident. If it is, then the material contributing cause standard applies. If not, then the major contributing cause standard applies.

Here, the medical evidence indicates that the original injury included left elbow symptoms. See Exs. 2A-1, 4A, 4B-1, 4B-2 and 4C. On September 21, 1992, Dr. Takas reported the gradual onset of severe pain in the elbow going down the left arm and diagnosed a left ulnar nerve lesion. (Ex. 5). Dr. Takas opined that claimant's ulnar nerve problem was a result of her training program, not a result of her compensable injury. In contrast, Dr. Baum opined that claimant's ulnar nerve condition was a latent result of the original injury. (Ex. 10).

We are more persuaded by Dr. Baum's opinion than that of Dr. Takas, because Dr. Takas did not have claimant's complete medical history. (Ex. 4A). Based on Dr. Baum's opinion, we conclude that claimant's left ulnar nerve lesion is directly related to the industrial accident. Consequently, we apply the material contributing cause standard and conclude that claimant's ulnar nerve condition is compensable. Kephart, supra; Gasperino, supra.

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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, claimant's counsel's 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 3, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JOHN C. IVANOFF, Claimant
WCB Case No. 91-16692
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
James W. Moller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Hazelett's order that upheld the SAIF Corporation's denial of claimant's aggravation claim and current condition claim for a left knee condition. On review, the issues are compensability and aggravation.

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

In Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), the court reversed a Board order which had held that a claimant's wrist nerve condition was not barred by a previous stipulation unless the claimant "intended to waive that right when she signed the stipulation." The court disagreed with our analysis. Instead, relying on Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), the court explained that the "correct inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement." Stoddard, supra, 126 Or App at 73. The court reasoned that, because the claimant's nerve condition had been diagnosed prior to the date the parties entered into the stipulation agreement (in which the parties agreed that the claimant's accepted wrist claim would remain closed), the claimant's nerve condition was an issue that could have been raised before that date. Id. Therefore, the court concluded, the claimant's wrist condition claim was barred by the settlement agreement.

In the instant case, claimant's left knee reflex sympathetic dystrophy (RSD) condition and ligament laxity claims are similarly barred by an August 1990 "Disputed Claim Settlement" (DCS). Claimant had sustained a left knee injury in November 1989, which SAIF accepted as a disabling "contusion." Claimant was first diagnosed with and treated for RSD related to the compensable injury in February 1990. By April 1990, claimant's left knee contusion and RSD were medically stationary. The claim was closed by Determination Order in May 1990, awarding claimant 26 percent permanent partial disability for lost knee range of motion.

After claimant fell in June 1990, his RSD condition worsened and additional treatment was recommended. Claimant requested a hearing challenging various aspects of claim closure and SAIF's alleged "de facto" denial of his aggravation claim. Thereafter, in August 1990, claimant and SAIF entered into a DCS wherein SAIF's denial of claimant's claims for aggravation and his current knee condition (as expressly included and appealed in the DCS) were upheld. The DCS further concluded that SAIF's denial "shall remain in full force and effect," and that the agreement "settle[s] all issues and claims raised or raisable at this time[.]"

Therefore, because claimant's RSD was diagnosed and medical services had been requested prior to the date the parties entered into the DCS, claimant's RSD condition was an issue that could have been raised before that date. Further, the medical evidence establishes that claimant's current left knee ligament laxity is a consequence of the RSD condition which was the crux of the 1990 aggravation claim settled by the August 1990 DCS. Under these circumstances, we find that claimant did not preserve the issue of the compensability of his left knee RSD (or consequential ligament laxity). Consequently, claimant's October 1991 aggravation and current condition claim for these conditions is barred by the settlement agreement. Stoddard, supra; Seney, supra.

ORDER

The Referee's order dated February 4, 1993 is affirmed.

Board Member Hall specially concurring.

While I respectfully disagree with the holdings in Seney, supra and Stoddard, supra, I am legally bound to follow the holdings of the Court of Appeals where they are factually applicable. I find no factual basis to distinguish the instant case from Seney and Stoddard, and therefore concur in this decision.

March 23, 1994 Cite as 46 Van Natta 470 (1994)

In the Matter of the Compensation of
GWEN A. JACKSON, Claimant
WCB Case No. 93-01851
ORDER OF ABATEMENT
Hollander, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

On March 7, 1994, we issued an Order on Review which: (1) set aside the insurer's "de facto" denial of claimant's proposed bilateral carpal tunnel surgery claim; (2) assessed an attorney fee under ORS 656.382(1) for unreasonable claim processing; and (3) declined to award an attorney fee under ORS 656.386(1) for claimant's counsel's services regarding the surgery claim. On our own motion, we are withdrawing our prior order for reconsideration.

Specifically, we intend to reexamine our conclusion that the court's holding in SAIF v. Allen, 124 Or App 183 (1993), precludes claimant from receiving an attorney fee award under ORS 656.386(1) for services devoted to the surgery claim. Should the parties wish to submit supplemental arguments on this issue, they may do so provided that their respective arguments are filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD JOHNSON, Claimant
WCB Case No. 92-12108
ORDER ON REVIEW
Davis, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband, Hall and Haynes.

Claimant requests review of those portions of Referee Mongrain's order that: (1) upheld the SAIF Corporation's denial of his occupational disease claim for a right shoulder condition; (2) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable discovery violation; and (3) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable denial. SAIF cross-requests review of that portion of the Referee's order that found that its discovery violation was unreasonable. On review, the issues are compensability, penalties and attorney fees.[1] We affirm in part and reverse in part.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant's work activities with SAIF's insured were the major contributing cause of his right shoulder condition.

SAIF's discovery violation was unreasonable.

SAIF's denial was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's right shoulder condition was not compensable because claimant failed to present sufficient medical evidence of causation supported by objective findings and because claimant was not a credible witness. Claimant argues that, because there is no medical evidence to contradict his treating physician's reports, the Referee's conclusion regarding compensability should be reversed. We agree.

The Referee found the claim not compensable for several reasons. First, he concluded that, from a lay perspective, claimant did not appear to be susceptible to an "overuse syndrome." However, a referee is not permitted to substitute his or her own opinion for the medical evidence in the record. See Robert B. Cummings, 45 Van Natta 11 (1993). Accordingly, we do not find the Referee's lay opinion a basis for finding that claimant's right shoulder condition is not compensable.

The Referee also concluded that claimant's right shoulder condition is not compensable because claimant was not a credible witness. Because the Referee did not evaluate claimant's credibility based on demeanor, we are equally able to evaluate claimant's credibility. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Raymond E. Aldinger, 45 Van Natta 2396 (1993).

At hearing, claimant admitted to having been convicted of the crime of receiving stolen goods. The Referee reasoned that this conviction cast all of claimant's statements into doubt. Therefore, when claimant's testimony regarding when he had reported his right shoulder condition to the employer conflicted with the employer's witness' testimony, the Referee concluded that a question existed regarding when claimant's condition arose.

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[1] SAIF also requests remand because the Referee refused to allow it to depose claimant's treating physician. In its brief, SAIF concedes that the basis for the requested deposition was claimant's counsel's refusal to foreclose the possibility of litigating the matter as an industrial injury claim. Inasmuch as claimant does not contest the Referee's treatment of the claim as an occupational disease claim, we need not address SAIF's request for remand.

We do not find such an issue to be dispositive, as we conclude that when claimant reported his condition is a different question than when his condition arose. In any event, the medical evidence unequivocally states that claimant's condition arose nine days before he first saw Dr. Townsend on August 13. (Exs. 3, 3a). In light of that uncontroverted medical evidence, we conclude that, in this case, a conflict in the parties' testimony regarding when claimant reported his condition to the employer does not provide a basis for concluding that a question exists regarding the onset of claimant's right shoulder condition.

Claimant must prove that his employment conditions were the major contributing cause of his right shoulder condition. ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures that contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145 (1983); Enid S. Crowe, 45 Van Natta 1718 (1993).

The existence of an occupational disease must be established by medical evidence supported by objective findings. ORS 656.802(2). "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).

We conclude that claimant's condition is supported by objective findings. The reports of Dr. Townsend, claimant's treating physician, specify that, on physical examination, claimant had "mild impingement signs," mild discomfort on supraspinatus testing and pain on apprehension testing. (Exs. 3, 3a). Those findings provide a sufficiently objective basis for claimant's condition. See ORS 656.005(19); Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992) (Physician's objective evaluation of a claimant's subjective complaints is sufficient to constitute objective findings).

Although we have found claimant's condition to be supported by objective findings, a separate inquiry is whether claimant has established medical causation. On this record, we conclude that the answer is "yes."

The causation of an occupational disease is a complex medical question that requires expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967). We generally give great weight to the opinions of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinion of Dr. Townsend, claimant's treating physician.

The only medical reports in the record are authored by Dr. Townsend. He opined that, on the basis of claimant's medical and work histories and examination, claimant's work "quite clearly" was the cause of his right shoulder condition. (Ex. 8). In rendering this opinion, Townsend considered significant the fact that claimant's work involved repetitive overhead work, that claimant had no history of right shoulder injury or disease, and that there was no other apparent cause for claimant's current condition. (Id.)

We find Dr. Townsend's opinion to be well-reasoned. Although he did not recite the precise statutory language set forth in ORS 656.802(2), he did consider the mechanism of claimant's condition, that claimant's symptoms arose at work, and the absence of other potential causes. These factors, coupled with the above-mentioned physical findings, led Dr. Townsend to conclude that claimant's work activities "quite clearly" were the cause of his right shoulder condition. (Id.) In light of that reasoning, and the fact that Dr. Townsend's reports are unrebutted, see Kenneth W. Devaney, 45 Van Natta 2333 (1993), we conclude that claimant has established that his work was the major contributing cause of his right shoulder condition. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

On review, SAIF argues that the Referee correctly discounted Dr. Townsend's opinion for lack of a complete and accurate history. Specifically, SAIF argues that, because the evidence reveals that Dr. Townsend was unaware of claimant's basketball and weightlifting activities, Dr. Townsend's opinions are entitled to little probative weight. We disagree.

There is no evidence in the record that claimant's recreational activities contributed to his right shoulder condition. To the contrary, Dr. Townsend specifically stated that claimant has "[n]o specific history of trauma to the shoulder," (Exs. 3, 3a), and that "there is no other apparent cause for the symptoms [claimant] suffered and for the resulting need for medical services." (Ex. 8). Furthermore, Dr. Townsend's findings are unrebutted.

For these reasons, we conclude that claimant's right shoulder condition is a compensable occupational disease.

Penalties for Discovery Violation

We adopt the Referee's conclusions regarding the unreasonableness of SAIF's discovery violation. Because we have concluded that claimant's right shoulder condition is compensable (and because we agree with the Referee that SAIF's discovery violation is unreasonable), there are sums now due on which to base a penalty.[2] Accordingly, pursuant to OAR 438-07-015(5) and ORS 656.262(10), we award claimant a penalty for SAIF's unreasonable discovery violation in the amount of 25 percent of the amount of compensation made due by this order as of the date of hearing, to be shared equally by claimant and his attorney, in lieu of an attorney fee award for services concerning the discovery issue. See Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992).

Penalties for Unreasonable Denial

The Referee concluded that, on the basis of the factors set forth in his opinion and order, SAIF's denial was reasonable and, therefore, did not support an award of penalties. Claimant argues that, because SAIF did not investigate his claim before issuing the denial, its denial was unreasonable. We agree.

A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt about 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 light of all the information available to the insurer at the time of denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). A legitimate doubt does not exist when the insurer precipitously denies a claim without conducting a reasonable investigation. See Kenneth A. Foster, 44 Van Natta 148 (1992), aff'd mem SAIF v. Foster, 117 Or App 543 (1993).

SAIF first received notice of claimant's occupational disease claim on August 31, 1992. (Exs. 1, 2). SAIF denied the claim three days later. (Ex. 5). The record reveals that the only information available to SAIF at the time of denial was Dr. Townsend's chart note, which stated that claimant's right shoulder pain began at work, that claimant had no specific history of right shoulder problems, and that claimant had objective signs of shoulder pain. (Exs. 3, 3a).[3] There is no evidence that SAIF investigated the claim. Because SAIF precipitously denied the claim and because Dr. Townsend's report should have prompted at least some investigation before issuance of a denial, we conclude that SAIF did not have a legitimate doubt as to its liability for the claim. Kenneth A. Foster, supra. Accordingly, we find the denial unreasonable.

Ordinarily, we would assess a penalty under ORS 656.262(10) for SAIF's unreasonable denial. However, we have already awarded a 25 percent penalty based on SAIF's unreasonable discovery violation. Since there is no legal authority for assessing a penalty totalling more than 25 percent of the compensation made due by an order, ORS 656.262(10), Robert A. Brooks, Jr., 44 Van Natta 1105 (1992), claimant is not entitled to a second penalty for SAIF's unreasonable denial.

Nevertheless, claimant may be awarded an attorney fee pursuant to ORS 656.382(1), if SAIF's unreasonable denial constituted different unreasonable conduct from that which supported the penalty. Felipe J. Casas, 45 Van Natta 2128 (1993); see Oliver v. Norstar, 116 Or App 333 (1992). It is. Accordingly, claimant is entitled to an attorney fee based on SAIF's unreasonable denial, as well as a penalty based on SAIF's unreasonable discovery violation. Felipe J. Casas, supra.

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[2] We note that SAIF did not comply with claimant's discovery request until after hearing. Inasmuch as we have set aside SAIF's denial, by the time SAIF corrected its discovery violation, there were amounts "then due" on which to base a penalty. See ORS 656.262(10); compare Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989).

[3] At the time of denial, SAIF may have also been in possession of an undated "827" form, which included claimant's statement of the claim: "Complained on the 4th of August about a shoulder injury that I got while working and then complained again on the 10th of August." (Ex. 4).

Having considered the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable insurer-paid fee concerning SAIF's unreasonable denial is $500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as reflected by the record and claimant's counsel's statement of services), the complexity of the issue, and the value to claimant of the interest involved.

Attorney Fee -- Compensability

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), we find that a reasonable attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $4,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's and reply briefs, the hearing record, and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 26, 1993 is affirmed in part and reversed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant is awarded a penalty for SAIF's unreasonable discovery violation in the amount of 25 percent of the amount of compensation made due by this order as of the date of hearing, to be shared equally by claimant and his attorney, in lieu of an attorney fee award for services concerning the discovery issue. The Referee's conclusion regarding the reasonableness of SAIF's denial is reversed. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning compensability and the reasonableness of SAIF's denial, claimant's counsel is awarded $4,500, to be paid by SAIF.

Board Member Haynes dissenting.

I strongly disagree with the majority's conclusion that claimant has met his burden of proving that his employment was the major contributing cause of his right shoulder condition. ORS 656.802(2). On this record, there has been an utter failure of proof. Accordingly, I would affirm the Referee's order.

The medical evidence is scanty at best. It consists of two cursory chart notes and a conclusory letter, authored by claimant's treating physician, Dr. Townsend. SAIF did not rebut this evidence. Although the Board ordinarily gives greater weight to a treating physician's opinions, there are persuasive reasons not to do so here. See Weiland v. SAIF, 64 Or App 810 (1983).

By way of recording claimant's history, Dr. Townsend's chart notes state only that claimant's shoulder pain "[s]tarted with his work which required him to do a lot of overhead working while changing oil filters. No specific history of trauma to the shoulder." (Exs. 3, 3a).

Townsend's letter is equally brief. In it, he said that claimant "worked in a 'grease pit' changing automobile oil and oil filters * * *." (Ex. 8). He also also noted that claimant's work required him to repetitively use his hands and arms overhead, and that claimant had no history of previous injuries or disease affecting the right shoulder. (Id.) On the basis of that history and claimant's objective findings, Dr. Townsend concluded that claimant had supraspinatus tendinitis, and that claimant's work in the grease pit "quite clearly" was the cause of that condition. (Id.)

Dr. Townsend's analysis and conclusion are fatally flawed because they lack a complete factual basis. See, e.g., Somers v. SAIF, 77 Or App 259 (1986); Luella M. Best, 45 Van Natta 1638 (1993). There is absolutely no evidence that Dr. Townsend was aware of claimant's extensive weightlifting and basketball activities. Because he had an incomplete history, Dr. Townsend was precluded from considering whether those activities could have contributed to claimant's right shoulder condition. See Pamela Wold, 43 Van Natta 362 (1991). For this reason alone, I would give Dr. Townsend's reports no probative value. See Troy L. Noel, 45 Van Natta 2048 (1993).

Moreover, although Dr. Townsend purported to consider the nature of claimant's overhead work, there is no evidence that Dr. Townsend considered how long claimant had been engaged in that work or how frequently claimant engaged in overhead maneuvers at work. Given the brevity of his reports, it appears that Dr. Townsend had only a superficial understanding of claimant's work activities. For this additional reason, I would credit Dr. Townsend's opinion with no weight. See Somers v. SAIF, supra; Luella M. Best, supra.

The majority is so influenced by the fact that Dr. Townsend's reports are unrebutted that it forgets is that it is claimant's burden to establish that his condition was caused, in material part, by his work exposure. See ORS 656.266; ORS 656.802(2). The only explanation for the majority's reasoning is that it believes that we are bound by uncontroverted expert evidence. We are not. John R. Hart, 35 Van Natta 665 (1983). Uncontroverted medical evidence will not satisfy a claimant's burden if it is insufficient as a matter of law. Because I would conclude that claimant's medical evidence is insufficient as a matter of law, I would disregard the fact that his evidence is uncontroverted.

For the foregoing reasons, I respectfully dissent.

March 23, 1994 Cite as 46 Van Natta 475 (1994)

In the Matter of the Compensation of
ROSIE B. LEAL, Claimant
WCB Case No. 92-14631
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband, Hall, and Haynes.

Claimant requests review of Referee Nichols' order that upheld the insurer's denial of her current psychological condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In 1983, claimant fell at work and compensably injured her upper back and neck. She eventually underwent surgery which fused her cervical spine at three levels.

In 1985, claimant sought psychiatric treatment for her chronic pain. Claimant appealed a July 1985 Determination Order and, in 1986, a referee's Opinion and Order found that claimant was permanently and totally disabled.

In September 1991, a Determination Order found that claimant was no longer permanently and totally disabled. Claimant requested a hearing and appealed the Determination Order. The matter was settled when the parties entered into a Claim Disposition Agreement (CDA) on August 25, 1992. The accepted conditions listed within the CDA included claimant's panic attacks, depression, anxiety reaction and chronic anxiety depression condition.

In September 1992, Dr. Glass, psychiatrist, examined claimant and diagnosed anxiety problems related to claimant's personality makeup. The insurer subsequently denied claimant's current condition on the ground that her current psychological condition was not related to her accepted condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant's current condition was not the same as her accepted psychological condition, and because her need for medical services was not related to her accepted condition, the claim was not compensable. We reverse.

We conclude that claimant has an accepted low back injury and a compensable psychological component. Claimant's treating psychiatrist, Dr. Wolgamott, reported that claimant had anxiety and panic sensations, in addition to a mild depression. Dr. Wolgamott prescribed medications for claimant's depression condition. Additionally, the CDA described claimant's accepted psychological condition as: "panic attacks, depression, anxiety reaction, chronic anxiety depression." Accordingly, because claimant has an accepted psychological condition, we conclude that the insurer may only deny her current condition if that condition is different from the accepted condition. See Eileen A. Edge, 45 Van Natta 2051 (1993).

Dr. Glass examined claimant on behalf of the insurer. Dr. Glass reported that claimant's continued anxiety problems were the result of a personality disorder, rather than being the residual of the injury. Dr. Glass did not believe that claimant was clinically depressed. Rather, he felt the claimant's symptoms were the result of hyperventilation and hysterical phenomena, rather than true panic attacks or an anxiety disorder.

We are not persuaded that Dr. Glass' report constitutes evidence of a changed or different psychological condition. Dr. Glass did not indicate that claimant's initial psychological problems had resolved. Furthermore, Dr. Glass believes that claimant's true psychological problem is an underlying personality disorder. However, because the insurer previously accepted claimant's psychological condition, we are not persuaded by Dr. Glass' opinion which indicates disagreement with the initial diagnosis of Dr. Wolgamott, and implies that claimant's problems were never work related.

Accordingly, because we find that claimant's current psychological problems are the same as her prior accepted condition, we conclude that the insurer's denial of her accepted condition constitutes a "back-up" denial of compensability.

In Anthony G. Ford, 44 Van Natta 240 (1992), we held that an insurer may issue a "back-up" denial of a claim more than two years after claim acceptance, so long as the insurer's denial is supported by a showing of fraud, misrepresentation or other illegal activity. Here, the insurer accepted the claim in 1983 and issued the "back-up" denial in 1992. Therefore, because the "back-up" denial was issued more than two years after claim acceptance, the insurer must prove fraud, misrepresentation or other illegal activity that was sufficiently material that the insurer's decision to accept the claim could reasonably have been affected. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987).

The insurer offers no argument, and we find no evidence that the insurer's denial was supported by a showing of fraud, misrepresentation or other illegal activity. Consequently, we conclude that the insurer's "back-up" denial is invalid and we set the denial aside.

Claimant's counsel is entitled to attorney fees for services at hearing and on review concerning the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review 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 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 June 4, 1993 is reversed. The insurer's November 4, 1992 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by the insurer.

Board Member Haynes dissenting.

I would affirm the Referee's order. First, I must respectfully disagree with the majority's interpretation of the insurer's denial as a denial of "compensability" of the accepted condition. The insurer's denial provides that claimant's September 1983 injury was accepted, with all benefits due having been paid in full. The denial specifically states that:

"Medical information received indicates your current psychological condition and your current psychological treatment are not due to your September 15, 1983 on-the-job injury. Since your September 15, 1983 on-the-job injury is not the major contributing factor to your current psychological condition and psychological treatment, including the prescriptions of Oxazepam and Desipramine, we must officially deny responsibility for these.

"Please note that this denial of your current psychological condition and treatment has no bearing upon your original September 15, 1983 accepted cervical claim."

A review of the insurer's denial establishes that the denial is a current condition denial, with no attempt to deny claimant's compensable condition. Therefore, I disagree with the majority's characterization of the denial as a "back-up" denial of the accepted condition.

Additionally, I find the facts of this case to be similar to the Board's decision in Stephen G. Meyer, 43 Van Natta 2655 (1991). In that case, the claimant contended that the insurer's denial of his current psychological condition was improper because the insurer had accepted the psychological condition in two prior stipulations. In Meyer, we held that the insurer's denial was not a "back-up" denial because the insurer did not dispute the compensability of the original claim. Rather, the insurer asserted that the claimant's current condition was unrelated to the accepted claim. We therefore upheld the insurer's denial because we found that the claimant had failed to establish that his current psychological condition was related to the accepted claim. Meyer, supra. Also see Queener v. United Employers Ins., 113 Or App 364 (1992); Green Thumb v. Basl, 106 or App 98 (1991).

Here, as in Meyer, I would find that the insurer's denial is a proper current condition denial, rather than a "back-up" denial of the claim. Furthermore, I would also find that, in this case, claimant has not met her burden of proof in establishing that her current condition is related to the accepted claim. Contrary to the majority's assertions, Dr. Glass did not find that claimant's past problems were not work related. Rather, Dr. Glass focused on claimant's current psychological problems. Specifically, Dr. Glass stated that, "[a]t this time the most appropriate psychiatric diagnosis would be: psychological factors affecting (claimant's) physical condition." (Emphasis supplied). Dr. Glass stated that the major cause of claimant's psychological symptoms and need for treatment was due to claimant's "characterologic factors" and chemical dependency, rather than to her injuries or medical conditions.

Consequently, I agree with the Referee's conclusion that claimant's current psychological condition is not the same as her compensable condition and is not related to the accepted claim. Claimant's treating psychiatrist, Dr. Wolgamott, previously reported that claimant had anxiety and panic attacks with mild depression. However, Dr. Glass, who has provided the only competent medical opinion in the record, has found that claimant's current condition is now "psychological factors" affecting claimant's physical condition. Dr. Glass was the only psychiatrist to examine claimant following the CDA, and he has opined that, as of the time of his examination, claimant had no psychiatric impairment as a result of her injuries, and any psychiatric treatment and diagnoses "are not caused by her injuries."

Finally, the majority apparently discounts Dr. Glass' opinion because it is contrary to the "law of the case." See Kuhn v. SAIF, 73 Or App 768 (1985). The majority implies that Dr. Glass is not persuasive because his opinion indicates that claimant's psychological condition was never work related. First, as explained above, I do not find any portion of Dr. Glass' opinion which states that claimant's prior psychological condition was not related to her injury. Moreover, I do not agree that this case is similar to Kuhn, supra. In Queener v. United Employers Ins., supra, the court found that the "law of the case" theory did not apply in a case where the doctors who examined the claimant were aware that she had previously suffered a compensable injury but found that her present symptoms were no longer causally related to it. (Emphasis supplied). That is the case here. Dr. Glass is aware of claimant's prior compensable injury and her treatment with Dr. Wolgamott. Dr. Glass' opinion that claimant's current condition is different and no longer related to the accepted condition does not contradict the "law of the case."

For the aforementioned reasons, I respectfully dissent. On the facts of this case, I would affirm the order of the Referee.

In the Matter of the Compensation of
HARRY L. LYDA, Claimant
WCB Case No. 92-04715
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The insurer requests review of that portion of Referee Herman's order that found that it accepted a chronic pain syndrome. On review, the issues are scope of acceptance and, alternatively, compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1983, claimant sought treatment for left neck, left shoulder and left arm pain following an incident at work when he attempted to pull open a file drawer. Dr. Athay, internal medicine specialist, treated claimant. In 1984, claimant sought treatment for right shoulder and upper back symptoms.

In February 1991, claimant returned to Dr. Athay for severe right neck and shoulder symptoms. On February 28, 1991, Dr. Athay informed the insurer that claimant had exacerbated his chronic cervical spine condition. (Ex. 64). Dr. Athay attributed the condition to the 1983 injury. (Exs. 64, 66). In June 1991, the insurer denied the compensability of such treatment on the basis that claimant's symptoms were not related to the 1983 injury. (Ex. 67).

In December 1991, claimant and the insurer entered into a stipulation. The agreement in part provided that "claimant alleged an injury on March 10, 1983. This claim was accepted as a nondisabling cervical strain." (Ex. 77-1). Furthermore, the document stated that, on February 28, 1991, Dr. Athay had submitted a letter which "claimant alleges is an aggravation claim" and that a denial letter had issued. (Id.) Finally, the agreement provided that the insurer would withdraw its denial and process the claim according to law. (Id. at 2).

In March 1992, the insurer issued a denial of the February 1991 aggravation claim described in the December 1991 settlement, stating that the "claim with the date of injury of March 10, 1983 has and remains accepted for neck, upper back, left arm and left shoulder pain." (Ex. 82).

The Referee, relying on Georgia-Pacific Corp. v. Piwowar, 305 Or 494 (1988), found that the insurer accepted the chronic pain syndrome condition by indicating in its denial letter that it had accepted neck, upper back, left arm and left shoulder pain. In particular, the Referee found that the insurer had accepted symptoms rather than a specific disease or condition and, therefore, had accepted any underlying disease or condition. The insurer disagrees, asserting that the record as a whole supports the conclusion that it accepted only a cervical strain.

Whether an acceptance occurs is an issue of fact. E.g. SAIF v. Tull, 113 Or App 449, 454 (1992). We find that the record in this case shows that the insurer accepted claimant's chronic pain syndrome. First, Dr. Athay described the condition as a chronic pain syndrome in his February 1991 letter to the insurer. The December 1991 stipulated agreement specifically referred to this letter as an aggravation claim and stated that it had been denied. The agreement then provided that the denial was rescinded and the claim accepted. (Ex. 77). We conclude that, inasmuch as the aggravation claim was based on a chronic pain syndrome and, because the insurer agreed to rescind its denial and process the claim in the December 1991 settlement, it accepted the chronic pain syndrome by operation of the stipulation. See Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). (Citing Timberline Equip. v. St. Paul Fire and Mar. Ins., 281 Or 639, 643 (1978) for the proposition that when an agreement is unambiguous, its interpretation is as a matter of law). This conclusion is further supported by the insurer's subsequent March 1992 denial stating that claimant's "neck, upper back, left arm, and left shoulder pain" remained accepted.

Consequently, based on the foregoing reasoning, we agree with the Referee that the insurer accepted the chronic pain syndrome.

Claimant's attorney is entitled to an attorney fee for services on 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 $1,000, 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 interest involved.

ORDER

The Referee's order dated May 27, 1993, as reconsidered June 9, 1993, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

March 23, 1994 Cite as 46 Van Natta 479 (1994)

In the Matter of the Compensation of
JOE H. RODGERS, JR., Claimant
WCB Case No. 93-03969
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of claimant's head injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant could have gone home if he felt it necessary. (Tr. 20). The employer was not preventing claimant from going home if he felt sick. Id.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that his injury was work related, finding that Benefiel v. Waremart, Inc., 112 Or App 480 (1992), was distinguishable. On review, claimant argues that Benefiel is controlling in this case. We agree with the Referee.

In Benefiel, the court stated the applicable law as follows:

> "A compensable injury is 'an accidental injury * * * arising out of and in the course of employment.' ORS 656.005(7)(a). A work-related injury is compensable, even if it is otherwise unexplained. See Phil A. Livesley Co. v. Russ, 296 Or 25, 30, 672 P2d 337 (1983). However, the fact that an employee is injured on the premises during working hours does not by itself establish a compensable injury. A claimant must show a causal link between the injury and the employment. 296 Or at 29." Benefiel, 112 Or App at 482-83.

The court concluded that the claimant's fall at work was not unexplained. The claimant in Benefiel had missed two days of work due to the flu and had called in on the day of the injury requesting another day off to recover. Although knowing that the claimant was ill, the employer had requested that the claimant come in to work. The claimant went to work in a weakened state and was required to perform stressful work activities. Specifically, she was required to run two checkstands. When she asked to be relieved because she was feeling faint, she was relieved of only one checkstand. She subsequently fainted, falling and injuring her knee. The court concluded that the claimant fainted because she was required to perform stressful work activities while in a weakened physical condition. Benefiel, supra at 483.

Here, claimant had experienced flu symptoms for a few days to a few weeks before the day of the injury. (Exs. 2, 3, 4-1, 10-1, Tr. 10). Although working 80 to 100 hours per week in the past, claimant testified that he had cut back on his hours before the injury due to his illness and was not working overtime. (Tr. 5, 8-9). Claimant had taken off the day before the injury as one of his normal days off. (Tr. 4). Claimant testified that he went into work on the day of the injury just before 1:00 to attend a mandatory staff meeting and that he had the day of the injury off except for the mandatory staff meeting. (Tr. 4, 21).

Claimant did not feel well during the staff meeting, but stayed after that meeting to complete some paperwork. While doing this paperwork, claimant began to feel weak and nauseous and went to the restroom where he fainted, falling, and striking the back of his head on the floor.

Claimant testified that he could have gone home if he felt it necessary and that the employer was not preventing him from going home if he felt sick. (Tr. 20). However, he stated that he did not remember whether he had asked permission to leave. Id.

Unlike Benefiel, the record in this case does not establish that claimant fainted because he was required to perform stressful work activities in a weakened physical condition. Although claimant was doing paperwork in a weakened physical condition, he acknowledged that he could have gone home if he chose to. Unlike Benefiel, the employer did not require claimant to stay and work while knowing that he was ill.

Furthermore, the insurer notes that, unlike the employer in Benefiel, it believes that this case presents a complex medical question requiring expert testimony to establish causation. Benefiel, supra at 482, fn 1. In addition, the insurer argues that the present case is complicated by the fact that claimant had previously suffered dizziness and loss of balance. (Exs. AA, B).

Although we do not necessarily agree with the insurer's interpretation of the court's footnote, we find that the medical evidence in this record does not relate the cause of the fainting episode to any work activity. There is no question that claimant's fall caused his head injury. Nor was this an unexplained fall -- claimant's fainting episode caused his fall. The issue is whether the cause of the fainting episode is work connected.

On December 30, 1992, Dr. Showerman, M.D., provided the initial emergency room treatment and diagnosed vasovagel syncope, minor occipital concussion, and probable recent influenza. (Ex. 4-1). Dr. Showerman does not give an opinion as to the cause of the syncope. On January 1, 1993, Dr. Garrard, M.D., provided subsequent emergency room treatment and diagnosed flu syndrome, mild post concussion syndrome, and mild dehydration. (Ex. 10-2). Dr. Garrard later evaluated the emergency room records and opined that claimant's viral illness probably caused the syncopal episode. (Ex. 15-1).

Due to claimant's ongoing post concussion syndrome symptoms, Dr. Garrard referred claimant to Dr. Melson, neurologist. Dr. Melson stated that the cause of the syncope remains unexplained. (Ex. 19). However, Dr. Melson did not have a history of claimant's flu condition. Thus, the only medical opinion to address causation that also has a complete history relates the cause of claimant's fainting episode to his flu condition. (Ex. 15-1).

Neither the circumstances of the fainting episode nor the medical evidence relate the cause of the fainting episode to claimant's work activities. On this record, claimant has failed to establish that his head injury is an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a).

ORDER

The Referee's order dated July 16, 1993 is affirmed.

In the Matter of the Compensation of
PHYLLIS SWARTLING, Claimant
WCB Case No. 92-09425
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Mongrain's order which: (1) declined to admit "post-closure" medical reports for the purpose of determining claimant's permanent disability; and (2) awarded claimant 5 percent (16 degrees) unscheduled permanent disability for the right shoulder, whereas an Order on Reconsideration had affirmed a Determination Order award of 1 percent (3.2 degrees); and (3) declined to award scheduled permanent disability for loss of use or function of the right arm. On review, the issues are evidence and extent of unscheduled and scheduled disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

"Post-Hearing" Evidence

During the time this case was awaiting Board review, claimant's claim was reopened for an aggravation of claimant's April 1991 injury. The claim was subsequently closed by Notice of Closure on March 10, 1993. The Notice of Closure was reconsidered on November 9, 1993 and claimant was awarded 23 percent (73.6 degrees) unscheduled permanent disability and 4 percent (6 degrees) scheduled permanent disability. The self-insured employer has submitted the November 9, 1993 Order on Reconsideration for our review.

We may 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. See e.g., Grace B. Simpson, 43 Van Natta 1267 (1991; Rita M. Duncan, 42 Van Natta 1854 (1990).

The Department's Order on Reconsideration 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. Inasmuch as the Department's recent reconsideration order pertains to claimant's compensable condition resulting from an aggravation claim which arose subsequent to the closure of the claim from which our review is based, the Department's recent reconsideration order has no relevance to the issue before us.

Evidence

The Referee did not admit Exhibit 16C, a document based on a "post-closure" exam by a physical therapist, or Exhibit 16D, the treating physician's concurrence with Exhibit 16C. Subsequent to the Referee's order, the Court of Appeals has held that, although the evidence that may be submitted on reconsideration before the Department of Insurance and Finance is limited by ORS 656.268(5), under ORS 656.283(7) the evidence that may be submitted at a hearing before a referee is not so limited. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

We applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report from the attending physician, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7), 656.283(7)) were applicable. Id. Here, there is no other basis preventing the admission of Exhibit 38A. Therefore, pursuant to Smith and Luciani, the Referee in this case had the authority to consider those exhibits.

In addition, we note that, although the examination that Exhibit 16C is based on was performed by a physical therapist, Dr. Gurney, claimant's attending physician, concurred with those findings. (Ex. 16D). Therefore, the findings in Exhibit 16C are not precluded by ORS 656.245(3)(b)(B). See Timothy J. Smith, 44 Van Natta 2246 (1992). Because the exhibits are in the record, we have considered them on review.

Extent of Scheduled Permanent Disability

We adopt the Referee's conclusion concerning the extent of claimant's scheduled permanent disability.

Extent of Unscheduled Permanent Disability

The Referee increased claimant's unscheduled permanent disability award from 1 percent (3.2 degrees), awarded by the Order on Reconsideration, to 5 percent (16 degrees). We modify.

Claimant became medically stationary on August 16, 1991, and her claim was closed by Determination Order on January 21, 1992. Because claimant 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 Determination Order control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. WCD Admin. Orders 2-1991, 7-1991.

The Referee concluded that, because claimant had returned to her regular work after the injury, claimant was not entitled, under the Director's disability rating standards (former OARs 436-35-290(2); 436-35-300(2); 436-35-310(2)), to consideration of the "non-impairment factors" of age, education and adaptability in rating her disability.

Claimant disagrees with the Referee's conclusion that she returned to her regular work. Former OAR 436-35-270(3)(c) defines "regular work" as substantially the same job held at the time of injury. Claimant's treating physician released her to modified work, with restrictions on heavy lifting, after her industrial injury. (Ex. 12). Her physician also noted that claimant had been doing her regular work after she returned to work. Claimant testified that she does not lift more than 25 to 30 pounds and uses her left arm, rather than her injured right arm, to perform some of her work duties. Accordingly, we conclude that claimant has returned to modified work. Therefore, we proceed to an evaluation of claimant's unscheduled permanent disability under the Director's disability standards.

Age

Claimant is 61. Accordingly, she is entitled to a value of 1 for age under the standards. OAR 436-35-290(2).

Education

Claimant has earned a high school diploma for a value of 0. OAR 436-35-300(2)(a). Claimant's highest SVP during the ten years preceding the time of determination is 4, as a stock clerk (DOT 299.367-014). Accordingly, claimant is entitled to a value of 3 under the standards. OAR 436-35-300(3)(e). Claimant does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less. Therefore, she in entitled to an additional value of 1. OAR 436-35-300(4). Claimant's education value is 4. OAR 436-35-300(5).

Adaptability

Claimant, relying on the latest version of the Dictionary of Occupational Titles (DOT), contends that her job should be characterized as "heavy." We disagree. The applicable "standards" define the DOT as the Fourth Edition, 1977 and its 1986 Supplement. OAR 436-35-270(3)(a). Accordingly, the strength requirement for claimant's regular work as a stock clerk, pursuant to the applicable DOT, is medium.

Claimant further contends that her residual functional capacity (RFC) is sedentary/light. We disagree. Although her physician filled in a blank listing claimant's RFC as "sedentary/light," he previously had released her with no "heavy lifting" and noted that claimant had been performing the same work as she did prior to her injury. Claimant testified that she had modified her work only to the extent that she did not lift any more than 25 or 30 pounds, and she used her left arm more frequently than before. Accordingly, we conclude that claimant's RFC is medium/light. OAR 436-35-270(3)(d). Therefore, claimant is entitled to an adaptability value of 2. OAR 436-35-310(3).

Impairment

The Referee concluded that claimant was entitled to an impairment value for a chronic condition limiting repetitive use of her right shoulder. We disagree.

The Referee relied on Dr. Gurney's opinion that claimant's compensable injury was the major contributing cause of her right shoulder condition, and that claimant should not lift anything more than 20 to 25 pounds above her shoulder level. Nevertheless, Dr. Gurney specifically stated that claimant had no chronic condition limiting repetitive use of her right shoulder. (Ex. 16A-6). Accordingly, we are not persuaded that claimant has a chronic condition limiting repetitive use of her right shoulder.

Claimant, relying on the range of motion measurements obtained by Mr. Williams, physical therapist, contends she is entitled to impairment awards, due to loss of range of motion, for her right shoulder, right hip and cervical spine. (Exs. 16C, 16D). We do not agree.

Although we have concluded that Exhibits 16C and 16D are admissible, there is no evidence that the reduced range of motion findings measured by Mr. Williams were caused by the accepted injuries. Notwithstanding the fact that Dr. Gurney signed his name indicating concurrence with the range of motion findings of Mr. Williams, there is nothing in the record relating the reduced range of motion findings to claimant's compensable injuries. ORS 656.214(2). Moreover, Dr. Gurney previously stated that claimant had normal range of motion in her neck and fairly good range of motion of her right shoulder, except in extreme abduction. (Ex. 13).

Furthermore, the record contains several references to severe degenerative changes in claimant's spine and right shoulder joint, and attributes her current complaints to those changes. (Exs. 8, 8A, 14). Finally, consulting physician, Dr. Serbu, neurologist, opined that there was a very large functional component present. (Exs. 9-2, 11).

The insurer acknowledges that claimant is entitled to 1 percent permanent impairment based on 10 degrees loss of range of motion for right shoulder abduction. OAR 436-35-330(5). Accordingly, we conclude that claimant's total impairment value is 1 percent.

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (5) is multiplied by the adaptability value (2), the total is 10. When this value is added to the value for impairment (1), the result is 11. Therefore, claimant's unscheduled permanent disability is 11 percent.

ORDER

The Referee's order dated November 13, 1992 is modified. In addition to the Referee's and Order on Reconsideration awards totalling 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, for a total award of unscheduled permanent disability to date of 11 percent (35.2 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, provided the total fees approved by the Referee and the Board does not exceed $3,800.

In the Matter of the Compensation of
RICHARD N. WIGERT, Claimant
WCB Case No. 91-02200
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Referee Spangler's order that set aside its partial denial of claimant's right ankle osteophyte condition and associated need for excision surgery. In addition, the insurer moves the Board for an order remanding the case to the Referee for the taking of additional evidence. On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, the insurer contends that the Referee erred in denying its request to reopen the record for the taking of a deposition from Dr. Dickerman, examining neurologist, or for the admission of Dr. Dickerman's recorded statement. The insurer also contends that, because of this error, the record was incompletely or otherwise insufficiently developed. We disagree.

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). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence 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). However, before we address the insurer's remand motion, we first respond to its contention that the Referee erred in denying the insurer's motion to reopen the record for further evidence.

OAR 438-07-025(1) allows a Referee discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that a party moving for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing. Renia Broyles, 42 Van Natta 1203 (1990). We review the Referee's evidentiary rulings for abuse of discretion. Id.

Here, the insurer requested reconsideration of the Referee's September 3, 1993 order and moved to have the record reopened for submission of additional evidence from Dr. Dickerman, examining neurologist. In response, the Referee abated his order and allowed claimant an opportunity to respond. On September 20, 1993, the Referee issued an Order on Reconsideration in which he denied the insurer's motion to reopen the record and republished his September 3, 1993 order in its entirety.

In requesting that the record be reopened, the insurer argued that it was surprised by claimant's testimony regarding his deafness, the loss of his hearing aid, and his resulting confusion during Dr. Dickerman's examination. The Referee responded that a party's surprise over the testimony is not a proper basis to allow reopening of the record and that the insurer was allowed full opportunity to cross-examine claimant. We agree. Furthermore, if a party is surprised by new evidence introduced at hearing, the remedy is for the "surprised" party to request a continuance. Kenneth W. Metzker, 45 Van Natta 1631 (1993).

The Referee also noted that, even if he reopened the record for the proffered evidence, it would not change the result. In reaching this conclusion, he noted that: (1) the written record and claimant's wife's testimony support claimant's testimony that his right ankle remained asymptomatic following his recovery from the noncompensable car accident which occurred in the 1950's; and (2) nothing in Dr. Dickerman's statement is probative as to claimant's state of mind during the May 1991 examination.

Although Dr. Dickerman believes that he took an accurate history regarding ongoing symptoms in claimant's right leg following the 1950's car accident, claimant credibly testified that he was confused during the examination because of his difficulty in hearing and understanding Dr. Dickerman's questions regarding his left and right legs, both of which had been previously noncompensably injured. As the Referee reasoned, it is claimant's state of mind that is probative, not Dr. Dickerman's. On this record, we find that the Referee did not abuse his discretion in refusing to reopen the record for further evidence from Dr. Dickerman.

With regard to the insurer's motion for remand, we are not persuaded, in light of the circumstances described above, that the evidence that the insurer seeks to have introduced on remand would be reasonably likely to affect the outcome of the case. Therefore, we are likewise unpersuaded that the current record is improperly, incompletely, or otherwise insufficiently developed without the proffered evidence from Dr. Dickerman. Accordingly, we deny the insurer's remand motion.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability issue with the following supplementation. The Referee found, and we agree, that Dr. Jones' opinions are most persuasive as to the cause of the need for surgical treatment to claimant's right ankle. (Exs. 7-5, 25, 29-2, 32, 42).

No physician, including Dr. Jones, disputes the fact that claimant had preexisting degenerative changes in his right ankle. However, prior to the 1990 work injury, the degenerative condition was asymptomatic. (Exs. 1-1, 1-4, 2-3, 3-3, 15-1). Dr. Jones' opinions establish that the work injury made the degenerative condition symptomatic, resulting in the need for surgery. ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). Thus, the insurer's partial denial must be set aside and the claim remanded to the insurer for processing according to law.

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), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 3, 1993, as reconsidered on September 20, 1993, is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the insurer.

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

On January 21, 1993, we issued an Order on Review that: (1) declined to award temporary total disability benefits after December 13, 1990, because the condition for which time loss was authorized remained in denied status; (2) assessed a penalty for an unreasonable failure to close the accepted sprain/contusion of the right foot and ankle; and (3) found that the insurer had not unreasonably resisted the payment of a diagnostic test. Richard N. Wigert, 45 Van Natta 88 (1993).

Asserting that a compensability issue that was pending before the Hearings Division may have a substantial impact on some of the issues in this case, claimant sought an abatement of our order to await resolution of that compensability issue. (WCB Case No. 91-02200). The insurer had no objection to such an abatement. Therefore, on February 16, 1993, we abated our January 21, 1993 order pending resolution of the compensability issue in WCB Case No. 91-02200.

As background information, WCB Case No. 91-02200 involved the propriety of the insurer's February 8, 1991 partial denial of claimant's right ankle osteophyte condition and associated need for excision surgery. On June 14, 1991, Referee Spangler upheld the insurer's partial denial. Claimant requested review of that order. On review, the Board remanded the case to Referee Spangler, directing him to reopen the record for additional evidence regarding claimant's right ankle condition and to proceed in any manner which would achieve substantial justice.

Following a hearing on August 6, 1993, during which both parties submitted additional evidence, Referee Spangler issued an order on September 3, 1993, as reconsidered on September 20, 1993. In that order, the Referee set aside the insurer's February 8, 1991 partial denial. Subsequently, the insurer requested Board review. On today's date, we affirmed Referee Spangler's order, as reconsidered. Richard N. Wigert, 46 Van Natta 484 (1994). Thus, claimant's current disability and need for treatment has been found compensable.

Given these circumstances and after further consideration, we issue the following order in place of our January 21, 1993 order.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the addition of the procedural history of WCB Case No. 91-02200 as recited above.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability Benefits

The Referee found that claimant was not entitled to temporary total disability compensation from December 13, 1990, because the condition for which time loss was authorized remained in denied status. On today's date, we issued an order in WCB Case No. 92-02200 in which we agreed with Referee Spangler's determination that the January 1990 work injury is the major contributing cause of claimant's current disability and need for treatment. Richard N. Wigert, supra. Accordingly, we affirmed Referee Spangler's September 3, 1993 order, as reconsidered on September 20, 1993. As a result, the insurer's denial has been set aside and the claim remanded to the insurer for processing according to law. We note that the injury in WCB Case No. 91-02200 is the same injury right foot/ankle injury as the one in the present case.

In the present case, claimant seeks temporary disability compensation based on the fact that his claim was reclassified in May 1991 as a disabling claim. As we subsequently explain, this reclassification was not properly challenged by the insurer. Claimant argues that he should receive temporary disability compensation because the accepted right foot/ankle strain and the degenerative condition are inseparable and this inseparable condition is disabling.

However, we need not address claimant's argument because claimant's current right ankle condition has been found compensable. On the merits of the compensable claim under WCB Case No. 91-02200, claimant is entitled to temporary disability compensation. As a result of our order regarding WCB Case No. 91-02200, the insurer is required to process claimant's claim, including the payment of temporary disability compensation.

Claimant is not entitled to a double payment of temporary disability compensation. Fischer v. SAIF, 76 Or App 656 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Thus, our decision in WCB Case No. 91-02200 resolves the temporary disability compensation issue in the present case, which involves the same injury.

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 nor the Referee's $800 insurer-paid attorney fee award concerning this issue. Consequently, we affirm and adopt those portions of the Referee's order.

Concluding that the insurer had a legitimate doubt as to its responsibility for the diagnostic test, the Referee declined to assess a penalty. We agree.

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." However, 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), we find 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 Allegedly 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's classification order. Finding no such abuse, we decline to consider the issue on review.

We turn to the processing issue. The Referee found that the insurer had unreasonably failed to close the accepted portion of the claim. However, finding that there were no amounts then due, he declined to assess penalties. We agree that claimant is not entitled to a penalty. However, we base our decision on the following reasoning. Given the fact that we have found in WCB Case No. 91-02200 that claimant's current disability and need for treatment are compensable, we find that the insurer did not act unreasonably in failing to close claimant's claim.

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).

Both at hearing and on review, claimant asserted that his condition was not medically stationary. (Tr. 20, Claimant's Appellant's Brief, page 5). However, although asserting that his condition was not medically stationary, claimant argued that he was entitled to an assessed penalty and attorney fee for the insurer's failure to close the claim. Id. Frankly, this argument is rather confusing. Claimant's claim may not be closed until his compensable condition is medically stationary. ORS 656.268(1). Obviously, if claimant's compensable condition is not medically stationary, the insurer does not act unreasonably in failing to close the claim.

Here, Dr. Dickerman, examining neurologist, and Dr. Struckman, examining orthopedist, both opine that claimant's accepted right ankle sprain is medically stationary and that his ongoing disability and need for treatment is caused by the preexisting degenerative condition. (Exs. 12-3, 16-5, -6, 20). However, we do not find these opinions persuasive because they are against the law of the case. As noted above, we have found that claimant's current disability and need for treatment is due, in major part, to the work injury. The record contains no persuasive opinion regarding claimant's medically stationary status.

To the contrary, the record indicates that claimant has had ongoing symptoms since his work injury and that further treatment has been recommended for those symptoms. In addition, we have found that claimant's current disability and need for treatment is compensable. On this record, claimant's compensable condition is not yet medically stationary. Therefore, it follows that the insurer's failure to close the claim is not unreasonable. Accordingly, claimant is not entitled to a penalty.

Attorney Fees on Review

Claimant's attorney submits a statement of services requesting an assessed fee of $2,300. However, since this dispute pertained to claimant's entitlement to temporary disability and because his counsel has been successful in obtaining that compensation, claimant's attorney is awarded a fee payable from that increased compensation. ORS 656.386(2); OAR 438-15-055(1). In accordance with the aforementioned rule, claimant's attorney is awarded 25 percent of this increased temporary disability, not to exceed $3,800, payable directly to claimant's attorney.

Accordingly, on reconsideration, the Referee's order dated October 25, 1991 is affirmed in part and modified in part. For the reasons previously expressed in this order, the insurer is required to process this claim and provide temporary disability benefits to claimant in accordance with law. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

March 24, 1994 Cite as 46 Van Natta 488 (1994)

In the Matter of the Compensation of
LLOYD S. ABRAHAM, Claimant
WCB Case No. 92-14829
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of those portions of Referee Michael V. Johnson's order that: (1) found that claimant filed an aggravation claim; and (2) set aside SAIF's denial of claimant's aggravation claim for a low back condition. On review, the issues are claim filing and aggravation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claim Filing

On review, SAIF contends that, because claimant did not "perfect" an aggravation claim, the Referee should not have addressed the merits of his aggravation claim. We disagree.

The Referee found that claimant's January 6, 1992, and May 5, 1992 submissions were insufficient to constitute prima facie evidence of an aggravation claim. The Referee concluded, however, that by issuing an aggravation denial, SAIF "legitimated" those submissions into an aggravation claim. We find, instead, that the Referee had jurisdiction to hear claimant's timely appeal from SAIF's denial.

Claimant forwarded to SAIF chart notes and a work release slip from Dr. Mitchell, his attending physician, as well as a May 5, 1992 letter requesting payment of temporary disability. SAIF treated those written submissions as an aggravation claim and issued a denial on October 16, 1992:

> "We have recently received information that you wish to reopen your claim because you feel that your condition has worsened.
>
> "Information in your file indicates there is no medical evidence your condition has worsened since the last award or arrangement for compensation. Therefore, we must deny your request to reopen the claim."

SAIF argues that it was appropriate for it to treat the documents submitted by claimant as a possible claim for aggravation and to issue a precautionary denial. We agree. See Henry Martin, 43 Van Natta 2651 (1991) (a "precautionary" denial is proper where a doctor's chart notes put an insurer on notice of a possible claim). Whether or not claimant "perfected" an aggravation claim, SAIF treated the submissions as an aggravation claim and issued a denial.

Once SAIF's denial issued, claimant had an obligation to request a hearing in response to the denied claim. See ORS 656.319(1); Naught v. Gamble, Inc., 87 Or App 145 (1987). More importantly, under ORS 656.319(1), a referee has jurisdiction over a denial where a timely request for hearing is filed. See Morelock Wood Products v. Baur, 105 Or App 371 (1991). SAIF does not contend that claimant's request for hearing was untimely. Accordingly, we find that the Referee had jurisdiction to address the merits of claimant's aggravation claim.

Aggravation

After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. ORS 656.273(1). We adopt and affirm the Referee's reasoning and conclusion that claimant established a compensable aggravation, with the following supplementation.

Claimant sustained a compensable low back injury in February 1990. After a period of conservative treatment, Dr. Mitchell released claimant for light duty work. On September 16, 1991, Dr. Mitchell declared claimant medically stationary. The doctor commented that claimant had "very little pain" in his back, and that he anticipated beginning light duty work for a different employer. Claimant's claim was closed by Determination Order on December 24, 1991 with awards of temporary disability benefits and 2 percent unscheduled permanent disability benefits.

Claimant returned to Dr. Mitchell on January 6, 1992, complaining of increased symptoms in his low back and right leg. Dr. Mitchell observed considerable stiffness in claimant's back, and commented that he must have "considerable pain." On March 9, 1992, claimant filed a request for reconsideration, challenging the permanent disability award. No party suggested that the claim was prematurely closed or that claimant was not medically stationary as of September 16, 1991.

On April 21, 1992, claimant was examined by medical arbiter, Dr. Bald. On June 2, 1992, an Order on Reconsideration issued awarding 7 percent scheduled permanent disability and 5 percent unscheduled permanent disability. A prior referee increased claimant's unscheduled permanent disability award to 25 percent. That order has not been appealed and has become final by operation of law. See ORS 656.295(8).

In determining that claimant's compensable condition had worsened, the Referee first decided that the December 24, 1991 Determination Order constituted "the last arrangement of compensation." The Referee's conclusion is consistent with our recent decision in Lindon E. Lewis, 46 Van Natta 237 (1994).

In Lewis, we held that the "base line" for determining whether the compensable condition has worsened is the evidence describing the claimant's "medically stationary" condition at or before the last award or arrangement of compensation (i.e., the last time the claimant was medically and legally determined to be medically stationary). Id. at 239. In reaching this conclusion, we reasoned that when a claimant contends that the compensable condition has worsened since the last award or arrangement of compensation, the analysis must start with locating the date the claimant was last determined, medically and legally, to be medically stationary. We explained that this approach is in accordance with the statutory requirement to evaluate an aggravation claim based on a worsening from the "last arrangement or award of compensation." ORS 656.273(1).

Here, claimant contends that his compensable condition worsened in January 1992, before the June 2, 1992 Order on Reconsideration issued. Claimant must establish that his compensable condition has worsened since the December 24, 1991 Determination Order. Lewis, supra at 241. Our review of the record confirms claimant's contention.

Dr. Mitchell reported that claimant sustained a symptomatic worsening of his back pain following his return to light duty work in late 1991. The doctor's chart notes reveal that while claimant had "very little pain" in his back and was able to perform light duty work in September 1991, by January 1992, claimant had considerable pain and stiffness in his back and was unable to work. Subsequently, Dr. Mitchell confirmed that claimant was unable to work from January to May 1992, due to his low back problems.

For these reasons, as well as those expressed by the Referee, we are persuaded that claimant's condition worsened after the December 1991 Determination Order. In addition, we agree with the Referee that claimant's worsened condition resulted in diminished earning capacity in excess of any expected waxing and waning. Inasmuch as claimant has carried his burden of proving that his condition worsened after the last award or arrangement of compensation, he has established a compensable aggravation.

Claimant's attorney is entitled to an assessed attorney fee for services on 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 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 interest involved.

ORDER

The Referee's order dated June 11, 1993 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JANET A. DANIEL, Claimant
WCB Case No. 93-02085
ORDER ON REVIEW
Dennis Henninger, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of that portion of Referee Hoguet's order which set aside, in part, its partial denial of claimant's current low back condition. On review, the issues are hearing procedure, compensability, and attorney fees.

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

In its appellate brief, SAIF argues that the Referee did not have jurisdiction to consider the compensability of claimant's L4-5 herniated disc condition. SAIF contends that claimant only filed a claim for, and SAIF denied, the compensability of her degenerative disc disease, not an alleged L4-5 herniated disc. SAIF further contends that the herniated disc claim was first made only one day before hearing, and that it never conceded that the L4-5 disc could be litigated at hearing. We disagree.

We have previously held that alternative theories of compensability may be considered, even when a theory is first raised in closing arguments, or considered by a referee sua sponte. Julie A. Gros (Pool), 45 Van Natta 1705 (1993) (new diagnoses raised in closing arguments may be considered); Murray L. Johnson, 45 Van Natta 470 (1993) (referee may decide claim on "new injury" theory not argued by parties).

Here, claimant sustained a work injury on September 1, 1992, which was accepted as a lumbosacral strain, but a claim for a herniated L5-S1 disc was denied. (See Ex. 15, affirmed by Board Order on Review issued October 20, 1993). Subsequently, claimant asserted that her preexisting degenerative disc disease compensably worsened as a result of the September 1992 work incident. (Ex. 18). SAIF issued a partial denial of claimant's "current treatment" for degenerative disc disease, asserting that the September 1992 injury was not the major contributing cause of claimant's condition. (Ex. 22). Claimant requested a hearing from SAIF's denial.

At hearing, the parties agreed the issue was compensability of claimant's degenerative disc disease. (Tr. 1-2). In opening argument, SAIF's counsel acknowledged the existence of L4-5 disc problems, but disputed the existence of any causal relationship to the September 1992 work incident. (Tr. 10).

The medical evidence revealed the presence of degenerative disc disease, including disc protrusion and disc herniation at L4-5. (See Exs. 9, 24, 26-6). The medical dispute focused on whether the September 1992 work incident pathologically worsened claimant's degenerative disc disease. Dr. Fuller, the examining orthopedist, opined it did not; while Dr. Berselli, claimant's treating orthopedist, opined that it did, as evidenced by the extruded L4-5 disc found in surgery. (See Exs. 28, 30).

Under these circumstances, we conclude that the herniated L4-5 disc, which the Referee found to be compensable, was part of, or was an alternative diagnosis of, claimant's current low back condition, not an "entirely different condition" as SAIF contends. See Julie A. Gros (Pool), supra. Accordingly, we find that the Referee had jurisdiction to determine the compensability of claimant's claim for a herniated L4-5 disc.

After our review of the record, we agree with the Referee's determination that SAIF's partial denial of claimant's current condition should be set aside insofar as it denies claimant's L4-5 disc herniation. Because we affirm the Referee's compensability determination, we also affirm the Referee's attorney fee award related to that determination.

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 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 9, 1993 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the SAIF Corporation.

Board Member Haynes specially concurring.

I write separately to explain the basis for my conclusion that the Referee had jurisdiction to decide the compensability of claimant's herniated disc.

Prior to the hearing, SAIF had issued a partial denial of claimant's degenerative disc disease. (Ex. 22). That denial defined the issues to be litigated at the hearing. In my view, that denial did not encompass an L4-5 herniated disc claim.

However, at the hearing, SAIF's counsel acknowledged the existence of claimant's L4-5 disc problems and specifically disputed the existence of a causal relationship to the work incident. (See Tr. 10). In essence, SAIF amended its partial denial to include denial of the L3-4 herniated disc, thereby placing that issue before the Referee.

Because SAIF denied the herniated disc claim at hearing, and thereafter did not object to litigating that issue, I conclude that the Referee had jurisdiction to decide the compensability of claimant's herniated disc claim.

In the Matter of the Compensation of
GEORGE O. HAMLIN, Claimant
WCB Case No. 93-02757
ORDER ON REVIEW
Max Rae, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Howell's order that affirmed an Order on Reconsideration which awarded claimant no additional unscheduled permanent disability for his neck and upper back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction.

Claimant's work as a bus driver (DOT # 913.463-010) has a Specific Vocational Preparation (SVP) value of 4.

Claimant was released by his attending physician in June 1992 to return to modified work as a bus driver.

CONCLUSIONS OF LAW AND OPINION

Supplemental Authority

Subsequent to the filing of Board briefs in this case, SAIF submitted a letter citing supplemental authority. Specifically, SAIF cited the Board's February 9, 1993 decision in George A. LaChapelle, 45 Van Natta 186 (1993). Claimant objects to SAIF's citation, contending that the submission should not be considered.

It is permissible for any party to provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. See Betty L. Juneau, 38 Van Natta 553, 556 (1986).

Here, the LaChapelle decision issued well before SAIF filed its respondent's brief on September 9, 1993. Therefore, we disallow SAIF's submission. We will not consider either SAIF's citation or claimant's argument with respect to the LaChapelle case.

Extent of Unscheduled Permanent Disability

In evaluating the extent of claimant's unscheduled permanent disability, the Referee applied the disability standards in effect on the date of the Notice of Closure, August 11, 1992, as modified by temporary rules that became effective June 17, 1993. WCD Admin. Order 6-1992 (effective March 13, 1992); WCD Admin. Order 93-052 (temp. rules, effective June 17, 1993).

Based on these standards, the Referee found claimant was entitled to 7 percent unscheduled permanent disability, based on the following values: age = 1; formal education = 1 and skills = 2, for a total of 3; adaptability = 1; and impairment = 3.24. However, because claimant had not shown permanent disability in excess of the 10 percent unscheduled permanent disability previously awarded, the Referee concluded that claimant was not entitled to any additional permanent disability compensation.

Claimant requested review, contending that he is entitled to a total award of 18 percent unscheduled permanent disability, based on his disagreement with the skills and adaptability values found by the Referee. The parties do not contest the impairment value of 3.24.

Subsequent to the Referee's order, the temporary rules set forth in WCD Admin. Order 93-052 expired. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules do not apply to all ratings. Rather, they apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the "standards" in effect at the time of the Determination Order or Notice of Closure. OAR 438-35-003(2). See Michelle Cadigan, 46 Van Natta 307 (1994).

Because claimant became medically stationary on July 20, 1992, and his claim was closed by Notice of Closure on August 11, 1992, the appropriate standards for rating claimant's disability are in the permanent rules adopted effective March 13, 1992. WCD Admin. Order 6-1992. Accordingly, we proceed to evaluate the extent of claimant's unscheduled permanent disability under those standards.

Pursuant to former OAR 436-35-290(2), 436-35-300(2), and 436-35-310(2), for workers who have a physician's release to regular work, or who have returned to regular work at the time of the determination, the value for the age, education and adaptability factors is zero. "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer." Former OAR 436-35-270(3)(c). Accordingly, we turn first to a determination of whether claimant was released to, or returned to, regular work.

Claimant was employed as a public transit bus driver at the time of his last aggravation, and he returned to the same job in June 1992. However, his attending physician released him to return to work with the permanent restriction of operating only buses with power steering. (See Exs. 3D, 12). Claimant testified that prior to his aggravation, he operated buses both with and without power steering. (Tr. 6, 11). At the time of his aggravation, claimant was driving a bus without power steering. (Tr. 6-7). Under these circumstances, we find that the job to which claimant was released, and to which he returned, was not substantially the same job he held at the time of his last disability, in that upon his release claimant was permanently restricted to driving only buses with power steering. See Barbara Clanton, 45 Van Natta 291 (1993) (claimant returned to same job, but with restrictions on performing her duties). Accordingly, we conclude that claimant was not released to, nor did he return to, his "regular work."

We proceed to rate claimant's unscheduled permanent disability pursuant to former OAR 436-35-270 to 436-35-440.

Age

A value of 1 is assigned for injured workers who are age 40 or above at the time of determination, and who do not have a physician's release to or have not returned to either their regular work or work requiring greater strength than the job at injury. Former OAR 436-35-290. Because claimant was more than 40 years old at the time of determination, he is entitled to a value of 1 for age.

Formal Education

A value of 1 is assigned for injured workers who do not have either a high school diploma or GED certificate at the time of determination, and who have not been released or have not returned to regular work. Former OAR 436-35-300(2), (3). Since claimant did not have a high school diploma or GED certificate at the time of determination, he is entitled to a value of 1 for formal education.

Education - Skills

The occupation assigned the highest SVP met by claimant based on the jobs he performed during the ten years preceding the time of determination is bus driver. Former OAR 436-35-300(4). This occupation is assigned an SVP of 4, entitling claimant to a value of 3. DOT 913.463-010; former OAR 436-35-300(4)(e).

Therefore, claimant is entitled to a value of 4 for the education factor. Former OAR 436-35-300(6).

Adaptability

The adaptability factor is based on a comparison of the prior strength demands of the worker's job at the time of injury with the worker's maximum RFC (Residual Functional Capacity) at the time of determination. Former OAR 436-35-310(1).

Claimant's job at the time of injury was "bus driver." This job is assigned a strength value of "medium" by the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT).

RFC is determined by the greatest capacity evidenced by: (1) the attending physician's release; (2) the preponderance of medical opinion; or (3) the strength of the job to which the worker has returned at the time of determination. Former OAR 436-35-270(3)(d).

Here, claimant returned to his job as a bus driver, which has a strength value of "medium" (M). However, he is permanently restricted by his attending physician to operating only buses with power steering. (See Exs. 3D, 12). Claimant testified that upon his return to work in June 1992, he has in fact operated only buses with power steering. (Tr. 8-9). There is no contrary medical evidence regarding claimant's residual functional capacity. Therefore, to determine claimant's RFC, we rely on his attending physician's release and the strength of the job to which claimant returned at the time of determination.

The record indicates that operating a bus with power steering requires pulling strength of 5-10 pounds, as compared to 20 pounds pulling strength to operate a bus without power steering. (Ex. 2D). Therefore, we conclude that claimant is unable to perform the full range of requirements of his medium strength job of bus driver. Accordingly, we find that claimant's RFC is "medium/light" (M/L), and he is entitled to an adaptability value of 2 (M to M/L). Former OAR 436-35-310(3).

Impairment

The parties do not contest the impairment value of 3.24, which is derived from the medical arbiter's examination. (Ex. 8).

We now assemble the factors to determine claimant's permanent disability. Adding the age (1) and education (4) factors results in a value of 5. Former OAR 436-35-280(4). That value is multiplied by the adaptability factor of 2, resulting in a value of 10. Former OAR 436-35-280(6). That product is then added to the impairment value of 3.24, resulting in a total of 13.24, which is rounded off to 13. Former OAR 436-35-007(13); 436-35-280(7). Thus, claimant is entitled to an award of 13 percent unscheduled permanent disability under the standards.

Because claimant has previously received an award of 10 percent unscheduled permanent disability, he is now entitled to an additional award of 3 percent (9.6 degrees) unscheduled permanent disability compensation. (See Ex. 3); former OAR 436-35-007(3).

ORDER

The Referee's order dated July 2, 1993 is reversed. The Order on Reconsideration is modified to award claimant 3 percent (9.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
CONNIE M. JOHNSON, Claimant
WCB Case No. 92-06467
ORDER ON RECONSIDERATION
Skalak & Alvey, Claimant Attorneys
Craig Creel, Defense Attorney

Claimant moved for reconsideration and abatement of our November 30, 1993 Order on Review. On December 27, 1993, we abated our order to consider claimant's motion and allow the insurer an opportunity to respond. Having received the insurer's response, we proceed with our reconsideration.

Our Order on Review affirmed and adopted the Referee's order upholding the insurer's denial of claimant's aggravation claim for a left knee condition. Furthermore, the order noted that, by agreeing with the Referee that claimant had failed to prove a compensable aggravation, the Board did not intend to suggest that claimant could not assert a valid medical services claim under ORS 656.245. Claimant contends that she proved a claim for anterior cruciate ligament repair surgery and asks the Board to enter an order finding the surgery compensable.

The insurer, in response, asserts that the sole issue litigated at hearing was aggravation and, therefore, the Board should decline to address the compensability of medical services. We first note that claimant's request for hearing included medical services among the issues to be litigated. Such an action is sufficient to allow the Board to address that issue on review. See Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458, 460 (1991) (case remanded to the Board to address an issue raised in pleadings before hearing).

We acknowledge that claimant's attorney agreed with the Referee's statement at hearing that the sole issue in the proceeding concerned aggravation. (Tr. 2). Without an express declaration, however, that claimant no longer wished to pursue the medical services issue, we find that she did not waive that question. Therefore, having found that medical services was sufficiently raised and not waived, we proceed to the merits.

Claimant sustained a compensable injury in 1990 and underwent surgery. In 1992, following claim closure, she experienced increased symptoms. Dr. North, claimant's treating knee surgeon, has recommended surgery to repair claimant's anterior cruciate ligament. According to Dr. North and Dr. Dinneen, orthopedist who examined claimant at the insurer's request, although not the major contributing cause, claimant's 1990 injury bears a causative relationship to her need for surgery. Based on this evidence, we conclude that claimant proved the surgery compensable. See ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993).

Claimant's attorney 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 the medical services issue, we find that a reasonable attorney for services at hearing and on review regarding this issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly reconsidered the time devoted to the issue (as represented by the record, claimant's appellant's and reply briefs, and claimant's request for reconsideration and reply to the insurer's response to that motion), the complexity of the issue and the value of interest involved.

Now, therefore, on reconsideration, the Referee's order dated March 8, 1993 is affirmed in part and reversed in part. The insurer's denial is set aside to the extent that it denied claimant's anterior cruciate ligament repair surgery. For services at hearing and on review regarding the medical services issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer. The remainder of the Referee's order is affirmed.

Board Chair Neidig dissenting.

Inasmuch as I disagree with the conclusions reached in the majority's opinion, I must respectfully dissent. I base my disagreements with the majority's decisions on the following reasoning.

To begin, the issue for resolution before the Referee was expressly described as "the compensability of an alleged aggravation." (Tr. 2). In response to the Referee's question regarding whether this statement of the issue was accurate, claimant's attorney stated "that's correct." (Id).

Thus, although claimant's hearing request identified the compensability of medical services as one of the issues for the hearing, claimant expressly limited the issue for resolution at the hearing as "aggravation." Consistent with this explicit acknowledgment, claimant identified the issue for resolution on review as "whether [she] sustained a compensable aggravation of her April 1990 compensable injury." (Appellant's Brief, Page 1). In light of these clear and unambiguous statements, I submit that it is inappropriate for the Board to now address the medical services issue on review.

Alternatively, this matter should be remanded to the Refere for further development of the record. As previously noted, both parties had agreed with the Referee's statement that the sole issue was aggravation. Since the majority is now permitting the supplementation of the disputed issues on review, I would consider this record to be insufficiently, incompletely, and inadequately developed to resolve the medical services issue. ORS 656.295(5). Under such circumstances, the majority should grant the insurer's request that this case be remanded to the Referee. See Murray L. Johnson, 45 Van Natta 470 (1993) (Board found compelling reason to remand when the claimant's hearing request raised occupational disease, injury, and aggravation theories but issues at hearing were confined to injury or aggravation theory and referee addressed occupational disease theory.)

Finally, if forced to review this medical services issue based on the current record, the record as presently developed does not establish the compensability of claimant's left knee anterior cruciate surgery. I reach this conclusion because claimant's compensable April 1990 injury no longer remains the major contributing cause of her resultant surgery. ORS 656.005(7)(a)(B).

It is undisputed that claimant had a preexisting condition stemming from March and June 1977 off-the-job left knee injuries. These injuries resulted in a June 1977 arthrotomy and medial meniscectomy. Claimant's compensable April 1990 left knee injury combined with that preexisting condition and resulted in a July 1990 surgery for a partial medial meniscus tear and an ACL excision performed by Dr. North. The compensable injury and surgery culminated in a 20 percent scheduled permanent disability award pursuant to a January 1991 Notice of Closure.

In January 1992, after returning to her work as a carpenter's apprentice (subject to squatting and crawling restrictions), claimant's left knee complaints gradually increased, prompting her return to Dr. North. After discussing conservative and invasive options with Dr. North, claimant chose further surgery in an attempt to stop the knee's progressive disability. (Ex. 4-23).

The insurer referred claimant to Dr. Dinneen, orthopedist. In February 1992, Dr. Dinneen attributed claimant's "current need for treatment" to her April 1990 compensable injury. Nevertheless, in light of claimant's previous injuries, Dr. Dinneen concluded that claimant's proposed anterior cruciate ligament repair surgery was due in a major contributing fashion to "previous injuries and not to the April 19, 1990 [work] incident."

In April 1992, Dr. North concluded that the major contributing factor for claimant's need for surgery was her preexisting anterior cruciate ligament tear. Dr. North characterized claimant's April 1990 compensable injury as "a material contributing factor."

In June 1992, in response to claimant's counsel's request for further information, Dr. North expanded on his prior opinion. Although claimant had a preexisting anterior cruciate insufficiency, Dr. North noted that she had not required medical treatment and was able to perform many activities without difficulty until the April 1990 industrial injury. In light of such circumstances, Dr. North concluded that the industrial injury played "a significant role in her not being able to cope with her knee at this time." (Dr. North characterized the injury as the "tire that blew out" or the "straw that breaks the camel's back").

Considering Dr. North's prior description of the compensable injury as a minor contributing factor in claimant's need for further surgery, I do not find Dr. North's subsequent conclusion that the injury played "a significant role" in claimant's disability sufficient to satisfy the statutory prerequisite that the compensable injury be the major contributing cause of claimant's resultant surgery. ORS 656.005(7)(a)(B). Since the remaining medical evidence relates claimant's need for surgery to her previous injuries and not to her compensable injury, I can reach no other conclusion than that her ACL surgery is not compensable.

This reasoning is not inconsistent with the Board's prior order. My intention in signing the prior decision containing the supplementation and reference to the Beck holding was merely designed to remind the parties that claimant remained entitled to future medical service attributable to her compensable injury. It was not my intention to suggest that claimant could now assert a medical services claim for the same surgery which formed the basis for her aggravation claim that we had agreed with the Referee was unrelated to the compensable injury.

In conclusion, I consider it inappropriate for the Board to now entertain this medical services issue. Secondly, if required to address the issue, I contend that the case must be remanded for further development. Finally, were it necessary to resolve the medical services issue based on this record, I would conclude that claimant's compensable injury is not the major contributing cause of her resultant surgery. For all of the aforementioned reasons, I respectfully dissent.

March 24, 1994 Cite as 46 Van Natta 497 (1994)

In the Matter of the Compensation of
JEAN K. MOMAN, Claimant
WCB Case No. 92-16292
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Tenenbaum's order which: (1) set aside an Order on Reconsideration as premature; (2) declined to address the extent of claimant's permanent disability for the low back. On review, the issues are premature claim closure and extent of permanent disability. We reinstate and affirm the Order on Reconsideration.

FINDINGS OF FACT

Except for the last two paragraphs, we adopt the Referee's findings of fact, with the following supplementation.

Subsequent to the Referee's order, we reversed Referee Crumme's November 25, 1992 order which set aside the employer's partial denial of claimant's degenerative low back condition. We found that claimant's degenerative condition, diagnosed as lumbar spondylosis with degenerative changes at L3-4 and L4-5, was not compensable under either ORS 656.802 or 656.005(7)(a)(B). Jean K. Elliott-Moman, 45 Van Natta 2189 (1993) on recon 46 Van Natta 332 (1994).

CONCLUSIONS OF LAW AND OPINION

The Referee found, based on Referee Crumme's prior order, that claimant's condition was not yet medically stationary because further material improvement in her degenerative condition was reasonably expected with further treatment, including surgery. The Referee, thus, set aside the October 28, 1992 Order on Reconsideration on the ground that claimant's then compensable degenerative low back condition was not medically stationary.

When a claim involves more than one compensable condition, the claim may not be closed until all compensable conditions are medically stationary. Mark L. Ellingsen, 41 Van Natta 2048, 2050 (1988). However, because claimant's degenerative condition is not compensably related to her accepted claim, she has otherwise failed to establish that her claim was prematurely closed. Claimant has not received curative treatment for her compensable condition since March 1991. (Ex. 49-49). The proposed surgery was directed toward her noncompensable degenerative condition. Based on the above, we conclude that claimant was medically stationary at the time of claim closure in regard to her compensable condition.

Extent of Disability

The Order on Reconsideration found that claimant was not entitled to permanent disability based on the opinion of the independent medical examiners, Drs. Wilson and Neufeld, that claimant had no permanent impairment as a result of her injury. The reconsideration order further found that there was no persuasive evidence to the contrary.

In Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994), the court stated that under the statutory limitations of ORS 656.245(3)(b)(B) the impairment findings of an independent medical examiner could not be considered for purposes of evaluating a worker's disability.

However, we have held that impairment findings made by a nonattending physician may be considered where the attending physician has expressly ratified those findings. Alex J. Como, 44 Van Natta 221 (1992). We have also determined that ORS 656.245(3)(b)(B) does not preclude evidence concerning the causal relationship between the compensable injury and the permanent impairment. Thus, evidence from a nonattending physician can be considered to determine whether the claimant's permanent impairment was attributable to his compensable condition under ORS 656.214(5). Frank H. Knott, 46 Van Natta 364 (1994).

Here, we must first determine whether Dr. Misko or Dr. Bell was claimant's attending physician at the time of the August 1992 claim closure. At hearing, claimant contended that Dr. Bell was her attending physician at the time of claim closure. We agree.

In March 1991, Dr. Bell, who had treated claimant since September 1989, referred claimant to Dr. Misko for surgical evaluation because he had no further treatment to provide her. He assumed that Dr. Misko would then take over her care and that he would see her only if necessary. (Exs. 32, 49-44). Dr. Misko first saw claimant on March 15, 1991 and signed a Form 829 on July 12, 1991. (Exs. 31, 34). In May 1991, Dr. Misko requested authorization to perform surgery. Dr. Misko last saw claimant on November 1, 1991, pending authorization for surgery. Claimant returned to Dr. Bell's care in March 1992 until the surgery issue was resolved. (Exs. 32, 40A). Dr. Bell did not sign a Form 829. Because claimant was referred to Dr. Misko primarily for surgical purposes and surgery has not been performed and because claimant has returned to Dr. Bell for treatment, we conclude that Dr. Bell was claimant's treating physician at the time of claim closure.[1] ORS 656.005(12)(b).

Dr. Bell believed that claimant's degenerative condition was responsible for her ongoing pain complaints. (Ex. 40A). However, he also felt that claimant's degenerative condition was not work related. (Ex. 49-38). Dr. Bell declined to obtain a physical capacities evaluation, since he did not consider claimant medically stationary because of the need for surgery for the spondylosis. (Exs. 41A,

[1] The Referee excluded Exhibit 46A, a "post-closure" report from Dr. Bell based on an August 25, 1992 examination. The report was considered by the Department at the time of reconsideration. Since we have concluded that Dr. Bell was claimant' treating physician at the time of claim closure, we consider Exhibit 46A for purposes of evaluating claimant's disability.

43A). Dr. Bell subsequently reported that claimant had a chronic condition which left her unable to repetitively use her lumbosacral spine and that she was limited to sedentary work. We interpret Dr. Bell's opinions to indicate that claimant's current condition and resulting impairment are related to her noncompensable degenerative condition.

Dr. Wilson, neurologist, and Dr. Neufeld, orthopedic surgeon, examined claimant on March 6, 1992. They found marked pain behavior and reported that claimant's subjective complaints far outweighed the objective findings on examination. (Exs. 39, 46-40). The doctors further opined that claimant's lumbar spondylosis with degenerative changes preexisted her compensable injury. They concluded that claimant had no permanent impairment as a result of her compensable injury. (Ex. 39).

Dr. Bell did not comment on the impairment findings of Drs. Wilson and Neufeld, but he did concur that claimant's degenerative condition was not work related. (Ex. 49-38). Thus, although Dr. Bell did not expressly concur with Drs. Wilson and Neufeld's impairment findings, their opinion can be considered to determine whether claimant's permanent impairment is attributable to her compensable condition. Frank H. Knott, supra.

Based on the opinions of Drs. Bell, Wilson and Neufeld, claimant has no permanent impairment due to her compensable condition. She is, therefore, not entitled to an award of permanent disability. ORS 656.214(5); OAR 436-35-270(2). The Order on Reconsideration is affirmed.

ORDER

The Referee's order dated April 9, 1993 is reversed. The October 28, 1992 Order on Reconsideration is reinstated and affirmed.

March 24, 1994 Cite as 46 Van Natta 499 (1994)

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case Nos. 91-11547 & 91-11151
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Ogbin v. Georgia-Pacific Corporation, 123 Or App 631 (1993). The court has reversed our prior order, Orval R. Ogbin, 44 Van Natta 1566 (1992), which held that the Hearings Division lacked jurisdiction to consider an Order on Reconsideration that had issued without appointment of a medical arbiter. Citing Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court has reversed and remanded for reconsideration.

Preliminary Matters

As noted, in our prior order, we vacated the Referee's order for lack of jurisdiction. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992). In Pacheco-Gonzalez v. SAIF, the court reversed the reasoning we used in deciding Olga I. Soto, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316. See also Wickstrom v. Norpac Foods, Inc., 125 Or App 520 (1993).

In light of the Pacheco-Gonzalez holding, it is our general practice in cases such as this to remand to the Hearings Division for further development of the record. See Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993). In other words, we generally remand for consideration of the "post-reconsideration" medical arbiter report, as well as other testimonial and documentary evidence the parties wish to present.

However, here, as a result of subsequent events, we consider such an action to be unnecessary. Specifically, following issuance of the Order on Reconsideration, a medical arbiter was eventually appointed. That medical arbiter's report was considered by the Director, who then issued a second Order on Reconsideration. That second order was appealed and the medical arbiter report considered along with other testimonial and documentary evidence in a hearing before Referee Mongrain. The employer's request for Board review of that order is presently pending review (WCB 92-14350). Finally, the parties do not contend that remand for further evidence taking is required.

Instead, on remand, the employer has asked that our review of this case be consolidated with our review of Referee Mongrain's order. In response, claimant seeks dismissal of this case on the basis that the second Order on Reconsideration, and the litigation resulting therefrom, has essentially rendered this case moot. We disagree with claimant's reasoning.

The court has held that our jurisdiction to consider an Order on Reconsideration is not contingent on the validity of the order. Pacheco-Gonzalez v. SAIF, supra. Likewise, the court has determined that we have authority to consider a "post reconsideration" medical arbiter report even if the Order on Reconsideration issued prior to adoption of amended ORS 656.268(7). See Wickstrom v. Norpac Foods, Inc., supra.

Moreover, we have held that, where the Director has purported to abate and withdraw an Order on Reconsideration while Board review is pending, such an action does not render the issue raised on review moot. Marvin L. Thrasher, 45 Van Natta 565 (1993). We reasoned that, regardless of the validity of the Order on Reconsideration, the Hearings Division, and hence the Board, continued to have jurisdiction over the matter. See Steven B. Matthews, 45 Van Natta 1435 (1993); Marvin L. Thrasher, supra; Kenneth G. Moore, 45 Van Natta 16 (1993). Finally, the Director's rules provide for no mechanism by which to "recall" or reconsider an Order on Reconsideration once the order has been appealed.

The aforementioned reasoning persuades us that despite the issuance of the first Order on Reconsideration without appointment of a medical arbiter, jurisdiction over this case remained with the Board (notwithstanding our prior conclusion to the contrary). Since we retained jurisdiction to consider the "post reconsideration" medical arbiter report, it follows that any subsequent action taken by the Director concerning that appealed order would not alter our ability to review that timely appealed order. Consequently, we deny claimant's motion to dismiss and grant the employer's motion to consolidate our review with that of the record subsequently developed before Referee Mongrain. In reaching this conclusion, we do not dismiss claimant's request for hearing from the second Order on Reconsideration or the employer's request for Board review of Referee Mongrain's order.

FINDINGS OF FACT

Claimant has a compensable occupational disease claim for "hearing loss." (Ex. 6) (Exhibit numbers and transcript pages referred to in this order are from the exhibit list in WCB No. 92-14350 unless otherwise specified).

Claimant, a panel patcher, was hired by the employer on September 24, 1975. He left his employment after the mill closed in 1990.

Claimant was examined by his attending physician, Dr. Tate, on October 10, 1990. After correcting for presbycusis, Dr. Tate determined claimant's binaural hearing loss at 44.53 percent.

The claim was closed by Determination Order dated February 28, 1991, awarding 12.75 percent for hearing loss in the left ear. The employer requested reconsideration, challenging impairment findings. Claimant also requested reconsideration, but did not challenge impairment findings.

On August 8, 1991, an Order on Reconsideration issued granting claimant an award of 24 percent for hearing loss in the left ear. The employer requested a hearing seeking a reduction. Claimant filed a cross-request, seeking an increased award. A December 11, 1991 Opinion and Order by Referee Livesley issued, increasing claimant's award to 44.53 percent scheduled permanent disability for binaural hearing loss. The employer requested Board review. On July 31, 1992, an Order on Review issued, vacating the Referee's order for lack of jurisdiction. Orval R. Ogbin, supra. (Ex. 18). Claimant appealed to the court.

On September 4, 1992, the Director, on his own motion, purported to abate and withdraw the August 8, 1991 Order on Reconsideration for the purpose of continuing the reconsideration proceeding in order to obtain a medical arbiter's report. Consequently, a medical arbiter's examination was conducted by Dr. Springate on September 28, 1992. The audiogram taken that same day, however, was ruled invalid by Dr. Springate because claimant's responses to pure tone tests were inconsistent and did not coincide with the previous tests.

An Order on Reconsideration issued on October 30, 1992, reducing the 12.75 percent award issued by the February 28, 1991 Determination Order to zero. Claimant requested a hearing. On March 2, 1993, Referee Mongrain increased claimant's disability award to 44.53 percent scheduled permanent disability for binaural hearing loss in lieu of any or all previous awards. The employer requested review.

Meanwhile, on October 6, 1992, the court issued an order reversing and remanding our prior order for reconsideration citing to Pacheco-Gonzalez, supra.

CONCLUSIONS OF LAW AND OPINION

Evidence

The employer argues that Referee Mongrain erred in refusing to admit proposed Exhibit 5. Exhibit 5 is a "pre-closure" November 29, 1990 medical report from Dr. Ediger, an audiologist, who was asked to perform an examination of claimant on behalf of the employer. It was Dr. Ediger's opinion that claimant's hearing loss was not the result of his employment. His findings and conclusions were not ratified by the attending physician, Dr. Tate. OAR 436-35-007(8).

The Referee refused to admit Exhibit 5 on the basis that it was not relevant for purposes of rating or evaluating claimant's impairment. (Tr. 4). The employer seeks admission of the report, arguing that Dr. Ediger's findings and opinion are relevant for the purpose of undermining the persuasiveness of Dr. Tate's opinion as compared to that of Dr. Springate, the medical arbiter.

ORS 656.283(7) provides that 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. Further, the evidence for consideration at hearing is not limited to the record developed before the Director. See Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

However, ORS 656.245(3)(b)(B) provides that only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability. Thus, for the substantive purpose of rating extent, the findings of impairment made by Dr. Ediger are not probative due to the limitation imposed by ORS 656.245(3)(b)(B).

Turning to the impeachment issue, the Court of Appeals has recently held that an "independent medical examiner's impairment findings that the employer offers for impeachment are, nonetheless, findings regarding the workers' impairment that evaluate the disability." See Koitzsch v. Liberty Northwest,125 Or App 666 (1994). Noting that the legislature intended to permit only the attending physician to make such findings, the Koitzsch court concluded that the Board violated ORS 656.245(3)(b)(B) by receiving and considering the impairment findings of the independent medical examiner. Therefore, we conclude Exhibit 5 is not admissible for the purpose of impeaching Dr. Tate's impairment findings.

However, the employer argues that claimant's hearing loss is not attributable to the compensable injury. See ORS 656.214(2). We have recently held that, where the issue is whether the claimant's permanent disability is "due to the compensable injury" under ORS 656.214(5), the evidentiary restrictions found in ORS 656.245(3)(b)(B) do not apply. Such "causation" evidence relates to the threshold question of compensability. See Frank H. Knott, 46 Van Natta 364 (1994).

Here, Dr. Ediger's report can be interpreted as probative evidence that no causal relationship exists between claimant's hearing loss and the compensable injury. Although claimant's permanent disability pertains to a scheduled disability rather than an unscheduled disability as was the case in Knott, the same reasoning applies. (The pivotal inquiry under ORS 656.214(2) is the permanent loss of use or function of the injured member "due to the industrial injury.").

Extent of Permanent Disability

Both Referee Livesley and Mongrain found claimant entitled to 44.53 percent permanent disability based on the medical opinion offered by Dr. Tate, claimant's attending physician. We agree that claimant is entitled to this award.

Claimant's claim was closed on February 28, 1991. Therefore, we apply the standards effective January 1, 1989 (WCD Admin. Order 1-1989), as amended October 1, 1990 (WCD Admin. Order 15-1990). See OAR 436-35-003. Physical disability ratings shall be established on the basis of medical evidence supported by objective findings by the attending physician, or by other medical providers if concurred in by the attending physician, or by the medical arbiter. ORS 656.245(3)(b)(B); 656.268(7). Evaluation of the worker's disability by the referee shall be as of the date of the reconsideration order issued pursuant to ORS 656.268. ORS 656.283(7); Safeway Stores, Inc. v. Smith, supra. In this case, we use the first Order on Reconsideration dated August 8, 1991.

The employer argues that claimant is entitled to no disability award because his hearing loss is not due to the compensable injury. ORS 656.214(2) provides that when permanent 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.

It was Dr. Tate's opinion, based on an October 10, 1990 audiogram, that claimant had severe bilateral hearing loss, worse on the left, which was related to excessive noise at work. After correcting for presbycusis, Dr. Tate calculated claimant's permanent disability at 44.53 percent binaural hearing loss. (Exs. 3, 4).

It was the opinion of Dr. Ediger, based on test results dating from 1975, that claimant's hearing loss was not the result of claimant's employment. Rather, he speculated that there was a "possibility" that ear disease, not ruled out by tests, was responsible for claimant's hearing loss. (Ex. 5).

The medical arbiter, Dr. Springate, conducted an examination of claimant, to include an audiogram, on September 28, 1992. He concluded that the audiogram taken that date was invalid because claimant's responses to pure tone tests were inconsistent and did not coincide with the previous tests. Nonetheless, he found the previous hearing tests to be quite consistent, and thus, an accurate reflection of claimant's hearing loss. Based on the fact that there was "nothing to indicate that [claimant] had significant progression during the fifteen years at [the employer]," Dr. Springate concluded that claimant's hearing loss was unrelated to noise exposure at work. Dr. Springate opined that claimant's hearing loss was probably an inherited form of hearing loss. (Ex. 20).

In comparing the reports authored by Drs. Tate, Ediger, and Springate, we conclude that Dr. Tate's opinion is more persuasive. In forming their opinions, both Drs. Ediger and Springate were impressed by the fact that when test results presumably taken in 1975 were compared with test results taken in 1990 there was no "progression" of hearing loss. Thus, they concluded that claimant's hearing loss was preexisting and further that this hearing loss was not worsened by noise exposure at work.

However, we find Dr. Ediger's discussion of the "possibility" that ear disease is a causal factor to be speculative. In addition, we find Dr. Springate's conclusion that heredity is a causal factor unexplained. Finally, we note that both physicians in forming their opinions relied heavily on Exhibit 1-1 which purportedly listed the decibel levels of a September 18, 1975 audiogram. For reasons more fully explained below, we are unconvinced that this exhibit alone establishes preexisting hearing loss.

In contrast, we find Dr. Tate's opinion to be free from these defects. Dr. Tate was of the opinion that claimant's hearing loss was work related and therefore proceeded to provide an assessment of claimant's permanent disability. Moreover, as the attending physician, Dr. Tate had a greater opportunity to observe and evaluate claimant. Weiland v. SAIF, 64 Or App 810 (1983). Therefore, we find no persuasive reason to disregard the opinion of claimant's attending physician that claimant's hearing loss was due to the compensable injury.

In the alternative, the employer also argues that OAR 436-35-250(2)(a) is applicable to this case. This rule provides that compensation may be given only for loss of normal hearing which results from

on-the-job exposure. The rule also specifies that hearing loss which preexisted the work exposure, adequately documented by a pre-employment audiogram, will be offset against the hearing loss. (Emphasis supplied). The employer relies on Exhibit 1-1 as evidence of a pre-employment audiogram.

Claimant argues that we should not accept Exhibit 1-1 as adequate evidence of preexisting hearing loss because the exhibit shows that the entry reflecting a September 18, 1975 audiogram was made on February 3, 1981, some six years after claimant started working for the employer. Therefore, claimant questions the accuracy of the entry and urges us to give the document little weight.

As previously noted, we 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). Thus, the "best evidence" rule requiring the original document as opposed to a copy is inapplicable. Nonetheless, we are not convinced that Exhibit 1-1 satisfies the requirements of OAR 436-35-250(2)(a) as evidence of preexisting hearing loss.

Exhibit 1 is the employer's business document. Its apparent purpose is to record audiograms administered on the employer's premises. The first entry in the employer's record for claimant is dated February 3, 1981 and allegedly indicates that an audiogram was conducted on September 18, 1975, just shortly before claimant's employment.

Although we acknowledge that the entry shows decibel levels for both ears, "numbers" alone do not constitute a "pre-employment audiogram" as required expressly by the rule. We note that no one testified that such a test actually was conducted. Accordingly, we find that, although there is evidence of preexisting hearing loss, such loss was not adequately documented by a pre-employment audiogram as required by the rule.

Assuming, without finding, that a September 18, 1975 audiogram was indeed administered (although we note that claimant testified at hearing that his pre-employment physical did not include a hearing test (Tr. 8, 10)), all the employer had to do was to maintain the document which recorded those levels. In this case, the employer failed to do so.

Consequently, because we find no adequate documentation of a pre-employment audiogram exists, we decline to offset claimant's recorded work-related hearing loss (as found by Dr. Tate) by any pre-employment hearing loss. (Ex. 4). Accordingly, claimant is entitled to a scheduled permanent disability award of 44.53 percent (85.50 degrees) for his binaural hearing loss. See ORS 656.214(2)(g).

Attorney Fees

We turn to a determination of claimant's attorney fee award. In a case in which a claimant finally prevails after remand from the Court of Appeals, the Board shall approve a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991).

Here, the employer requested a hearing concerning the August 8, 1991 Order on Reconsideration which awarded claimant 24 percent for hearing loss in the left ear. The employer sought to have this award reduced. Referee Livesley increased claimant's scheduled permanent disability for a total of 44.53 percent. In addition, Referee Livesley awarded a carrier-paid attorney fee of $1,000. See ORS 656.382(2). On remand, we have affirmed the Referee's award. Claimant did not finally prevail on this issue until issuance of this order. Thus, claimant is entitled to a reasonable attorney fee for finally prevailing against the employer's request for reduction of claimant's scheduled permanent disability award before every prior forum. ORS 656.388(1).

In making such a determination, we consider the factors set forth in OAR 438-15-010(4). After applying those factors to this case, we find that a reasonable fee for claimant's attorney's services on Board review, before the court, and on remand 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 claimant's appellate briefs and his counsel's statement of services for Board review), the complexity of the issues, the value of the interest involved, the result secured for claimant, and the risk that claimant's counsel

might go uncompensated. This award is in addition to the $1,000 carrier-paid attorney fee granted by Referee Livesley, which we find reasonable based on the aforementioned factors.

Accordingly, on reconsideration, Referee Livesley's order dated December 11, 1991 is affirmed. For services before the Board on review, the court, and the Board on remand, claimant is awarded an assessed attorney fee of $3,000, to be paid by the employer.

IT IS SO ORDERED.

March 24, 1994 Cite as 46 Van Natta 504 (1994)

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case No. 92-14350
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

The self-insured employer requests review of Referee Mongrain's order that awarded claimant 44.53 percent (85.50 degrees) scheduled permanent disability for binaural hearing loss, whereas an October 30, 1992 Order on Reconsideration declined to award scheduled permanent disability. In its brief, the employer argues that the Referee erred in refusing to admit proposed Exhibit 5 (a medical report from Dr. Ediger who conducted an examination at the employer's request). In the event claimant's compensation is not reduced, claimant seeks an attorney fee under ORS 656.382(2). On review, the issues are evidence, extent of scheduled permanent disability, and attorney fees.

As explained in our Order on Remand (WCB Nos. 91-11547 and 91-11151) issued this date, we have conducted our review of this record in conjunction with our review of the record developed in that case. Orval R. Ogbin, 46 Van Natta 499 (1994). The findings, reasoning, and conclusions contained in our Order on Remand are hereby incorporated by reference into this order.

In accordance with our Order on Remand, Referee Mongrain's order dated March 2, 1993 which awarded claimant 44.53 percent (85.50 degrees) binaural hearing loss has been affirmed. In making this decision, we wish to emphasize that claimant's total scheduled permanent disability award for binaural hearing loss equals 44.53 percent (85.5 degrees). In other words, our affirmance of Referee Mongrain's order does not represent an award of scheduled permanent disability in addition to that granted by our Order on Remand issued this date.

Inasmuch as claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee on Board review. ORS 656.382(2). In making such a determination, we consider the factors set forth in OAR 438-15-010(4). After applying those factors to this case, we find that a reasonable fee for claimant's attorney's services on Board review is $900, 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 and statement of services), the complexity of the issue, and the value of the interest involved. This award is in addition to the attorney fee award granted by our Order on Remand.

ORDER

The Referee's order dated March 2, 1993 is affirmed. For services on Board review, claimant's attorney is awarded $900, to be paid by the self-insured employer.

In the Matter of the Compensation of
LORENZO OROZCO-SANTOYA, Claimant
WCB Case No. 92-14664
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Claimant requested reconsideration and abatement of our January 27, 1994 Order on Review that affirmed the Referee's order awarding 5 percent unscheduled permanent disability for a right shoulder condition. On February 25, 1994, we withdrew our order. Having received the insurer's response, we proceed with our reconsideration.

With regard to adaptability, claimant challenges our finding that claimant's job at the time of his injury qualified as Grain Farmworker I, DOT 401.683-010, which has a strength demand of medium. Claimant asserts that the proper category for his work is Hops Farmworker, DOT 404.687-010, which has a strength demand of heavy. The insurer agrees with claimant that Grain Farmworker I was not the appropriate classification in this case and suggests that the more proper category is Farm Worker, Field Crop I, DOT 404.663-010.

The record shows that claimant was harvesting hops when he was injured. (Ex. 7). With regard to his specific duties, the record indicates only that claimant dumped "hop debris" and performed "belt work." (Ex. 10-2). We agree with the parties that such work does not qualify as Grain Farmworker I, which in large part pertains to the operation of farm equipment to plant, cultivate, harvest and store grain crops. DOT 401.683-010. Similarly, we disagree with the applicability of Field Worker, Field Crop I, DOT 404.663-010, since it describes the operation of farm equipment for hops. We also do not agree with the applicability of Field Crop Farmworker II, DOT 404.687-010, since it includes planting and cultivating, as well as harvesting, field crops.

Based on claimant's work activities, we find that the most appropriate description of his job is that of Field Crop Harvest Worker, DOT 404.687-014, which pertains only to the harvesting of various field crops, including hops. See William L. Knox, 45 Van Natta 854 (1993) (In determining the proper DOT job description, the Board considers the record as a whole, as it relates to job duties as well as strength demands, to find the position which appropriately describes claimant's job at injury). The strength category of this job is heavy. Since this strength demand differs from the medium category upon which the initial Order on Review was based, it is necessary to redetermine claimant's extent of permanent disability.

Our order found that claimant's RFC was medium based on the opinion of Dr. Poulson rather than Dr. Burr. The insurer requests that we reconsider our assessment of the medical opinions and place more emphasis on Dr. Burr's opinion. We deny the insurer's request and continue to defer to Dr. Poulson's opinion for the reasons stated in our order.

Comparing the "medium" RFC to the "heavy" strength demand at the time of injury results in a value of 3 for adaptability. See OAR 436-35-310(3) (WCD Admin. Order 6-1992).

Claimant was older than 40 at the time of determination, entitling him to a value of 1. See OAR 436-35-290(1).

Claimant also is entitled to a value of 1 for education since the record shows that he has not earned a high school diploma or GED. See OAR 436-35-300(2)(b). With regard to the skills factor, according to a vocational assistance counselor, 5 was the highest SVP met by claimant based on the jobs he performed during the ten years preceding the time of determination. (Ex. 27-3). Specifically, the counselor found that claimant worked as a Fruit Farmworker I, DOT 403.683-010. (Id.)

In his brief on review, claimant asserted that, for purposes of determining his highest SVP, his job duties were more similar to that of Fruit Farmworker II, DOT 403.687-010, which has an SVP of 2. We disagree. The record shows that claimant's activities included spraying and trimming apple trees. (Exs. 10-2, 27-3). Furthermore, there was evidence that claimant operated a tractor. (Ex. 10-3). All of these activities are included among those performed by Fruit Farmworker I and, therefore, we find this

to be the applicable category. Thus, we find that the highest SVP attained by claimant during the relevant time period is 5, which entitles him to a value of 2. See OAR 436-35-300(4)(e). Adding the value for claimant's formal education results in an education factor of 3. See OAR 436-35-300(6).

The value for age and education is 4. See OAR 436-35-280(4). Multiplying that value with the adaptability factor of 3 results in a value of 12. See OAR 436-35-280(5). There is no dispute that claimant has establishes entitlement to a 5 percent value for impairment. Thus, claimant is entitled to an award of 17 percent unscheduled permanent disability. See OAR 436-35-280(7).

At hearing, the parties stipulated to the existence and amount of an overpayment by the insurer to claimant. Although not awarding any additional permanent disability, the Referee authorized an offset by the insurer against any future awards of permanent disability. See ORS 656.268(13); Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); Steve E. Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 517 (1993).

In its brief on review, the insurer requested an offset of an overpayment against any additional permanent disability awarded on review. There was no objection by claimant. In view of the stipulation at hearing regarding the overpayment and the absence of any objection by claimant to authorizing an offset on review, we grant the requested offset. Id.

Therefore, on reconsideration, we republish our January 24, 1994 order except for that portion regarding extent of permanent disability. Based on the reasoning provided in this order, in addition to the Referee's and the Order on Reconsideration's award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees), giving claimant a total award of 17 percent (54.4 degrees) unscheduled permanent disability. The insurer is authorized to offset this permanent disability award by the stipulated $767.02 overpayment. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. However, this attorney fee shall not be subject to the aforementioned offset for the prior overpayment of compensation. See OAR 438-15-085(2).

IT IS SO ORDERED.

March 24, 1994 Cite as 46 Van Natta 506 (1994)

In the Matter of the Compensation of
PHILIP A. STERLE, JR., Claimant
WCB Case No. 92-13981
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Holtan's order that affirmed the Order on Reconsideration to the extent that it awarded no additional permanent disability beyond that which had been previously awarded for claimant's low back, right leg, and left leg conditions and which declined to grant an award for claimant's psychological condition. On review the issues are extent of unscheduled and scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his impairment findings regarding the lower extremities, and as further supplemented below.

On February 14, 1991, Dr. Slack examined claimant. Based on this examination, he rated claimant's low back and lower extremities. On February 12, 1991, Dr. Dixon reviewed claimant's medical records. Based on this review, he rated claimant's psychological condition. The attending physician, Dr. Wayson, concurred in the February 1991 reports of Drs. Slack and Dixon.

Claimant was examined by Western Medical Consultants on July 14, 1992. Dr. Wayson concurred in the panel's findings and conclusions.

Claimant's loss of psychological function is due to a psychoneurosis, class 2, with a gradation of moderate.

CONCLUSIONS OF LAW AND OPINION

The September 1, 1992 Determination Order awarded claimant 21 percent unscheduled permanent disability for a low back condition and nothing for claimant's psychological, right leg and left leg conditions. (Ex. 83B). The October 14, 1992 Order on Reconsideration affirmed the Determination Order in all respects. (Ex. 85). At hearing, the Referee found that under the standards claimant was entitled to 31 percent unscheduled permanent disability for the low back, 10 percent scheduled permanent disability for the right leg, 5 percent scheduled permanent disability for the left leg, and nothing for the compensable psychological condition.

However, because claimant had previously been awarded 49 percent unscheduled permanent disability for the low back, 10 percent scheduled permanent disability for the right leg, and 5 percent scheduled permanent disability for the left leg in the same claim, the Referee concluded that claimant was not entitled to any further awards. On review, claimant seeks an award of 62 percent unscheduled permanent disability for his low back and psychological condition, 14 percent scheduled permanent disability for the right leg, and 14 percent scheduled permanent disability for the left leg.

Any time a worker ceases to be enrolled or actively engaged in training pursuant to ORS 656.268(8), the worker is entitled to have the amount of permanent disability for an accepted condition reevaluated under the standards. OAR 436-35-007(6). Here claimant's vocational rehabilitation training was terminated. As a result, the Department reevaluated claimant's claim and issued a Determination Order dated September 1, 1992.

Therefore, we apply the standards effective March 12, 1992 (WCD Admin. Order 6-1992), as amended June 11, 1992 (WCD Admin. Order 11-1992). See OAR 436-35-003. Evaluation of the worker's disability shall be as of the date of the reconsideration order issued pursuant to ORS 656.268. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

Unscheduled Permanent Disability

Claimant seeks an unscheduled award of 62 percent for his low back and psychological condition. Claimant relies on the reports of Dr. Slack and Dr. Dixon for impairment findings. (Exs. 63, 66).

At hearing, the employer objected to these exhibits. (The Referee and the insurer apparently identify the report of Dr. Dixon as Exhibit 64. The record, however, indicates that the correct exhibit designation is Exhibit 66.) The insurer's objection was overruled and the exhibits were admitted into evidence. On review, the insurer renews its objection on two grounds.

The first ground was because the exhibits were not considered for purposes of impairment at the prior hearing before Referee Crumme where the issue was extent of scheduled and unscheduled permanent disability stemming from the September 26, 1990 Determination Order and June 7, 1991 Order on Reconsideration. At that hearing, Referee Crumme ruled that Exhibits 61A and 62A (now Exhibits 63 and 66) were admitted "for purposes other than as findings of impairment for purposes of evaluating the extent of claimant's disability." The basis of Referee Crumme's ruling was that Dr. Wayson had not ratified those opinions. (Ex. 71-1). When Referee Crumme issued his March 11, 1992 Opinion and Order, Dr. Wayson had yet to author his September 24, 1992 letter indicating his concurrence with the findings and conclusions of Drs. Slack and Dixon. (Exs. 71, 84-3).

The second ground for objecting was that the September 24, 1992 concurrence letter of Dr. Wayson did not rise to the level of an actual concurrence.

ORS 656.245(3)(b)(B) states that, "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." See Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). We have interpreted this provision to mean that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning the worker's impairment. Dennis E. Connor, 43 Van Natta 2799 (1991). We have further held that impairment findings from a physician, other than the attending physician at the time of claim closure, may be used only if those findings are ratified by the attending physician. Alex J. Como, 44 Van Natta 221 (1992). See also OAR 436-10-080(5).

In conjunction with this provision, ORS 656.214(5) provides that the "criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis supplied). Thus, while ORS 656.245(3)(b)(B) limits evidence concerning permanent impairment, it does not limit other evidence, such as evidence concerning the causal relationship between the compensable injury and the permanent impairment, that is necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5). See Frank H. Knott, 46 Van Natta 364 (1994).

Here, claimant did not challenge impairment findings on reconsideration. Thus, no medical arbiter was appointed. Therefore, the only impairment findings that can be used to evaluate claimant's impairment are those found by Dr. Wayson, or ratified by him. Dr. Wayson found claimant medically stationary on September 4, 1990. At that time, he concurred in the July 27, 1990 report from Providence Hospital concerning claimant's impairment findings. (Exs. 57, 58, 59, 60). The record does not indicate that Dr. Wayson made impairment findings of his own.

Thereafter, on February 14, 1991, at the request of claimant's counsel, claimant was examined by Dr. Slack. (Ex. 63). On February 12, 1991, Dr. Dixon responded to a questionnaire from claimant's counsel addressing claimant's psychological impairment. (Ex. 66). On September 24, 1992, Dr. Wayson, in a response to a request, concurred with the "findings and opinions" contained in those reports. (Ex. 84-3). In his report Dr. Wayson acknowledged he had not seen claimant since June 1990. He also indicated that the reason he was concurring was because he had "no information whatsoever that would conflict with Dr. Slack's and Dr. Dickson's [sic] evaluations..." (Ex. 84-3). The Referee found the September 1992 report of Dr. Wayson did not rise to the level of a true concurrence. On review, we find Dr. Wayson's concurrence with the reports' "findings and opinions" adequate, and, therefore, consider the findings.

On July 14, 1992, claimant was examined by Western Medical Consultants on behalf of the insurer. (Ex. 78). Dr. Wayson concurred in their findings and conclusions on August 13, 1992. (Ex. 82).

No statutory provision prevents the admission and consideration of the above exhibits. First, there was no medical arbiter appointed. Consequently, the limitation found in ORS 656.268(7) does not apply. Second, the attending physician concurred with the reports' findings. Thus, there is no contravention of ORS 656.245(3)(b)(B) which provides that only the attending physician may make findings regarding the worker's impairment for purposes of evaluating disability. Koitzsch v. Liberty Northwest Insurance Corp., supra. Finally, the documents in question were submitted prior to issuance of the October 14, 1992 Order on Reconsideration. Therefore, the documents are properly considered under ORS 656.283(7). See also Gary C. Fischer, 46 Van Natta 60 (1994).

The fact that Exhibits 63 and 66 (formerly Exhibits 61A and 62A) were not considered for purposes of impairment at the previous extent hearing before Referee Crumme is irrelevant. Referee Crumme rated extent from a September 26, 1990 Determination Order and June 7, 1991 Order on Reconsideration. At issue here is a September 1, 1992 Determination Order and October 14, 1992 Order on Reconsideration issued pursuant to ORS 656.268(8). We have previously held that, under these circumstances, a worker is entitled to a new determination of his disability without regard to previous awards. Moreover, the worker need not show a worsening of his condition. John A. Gordon, 44 Van Natta 2079 (1992). Thus, the previous hearing before Referee Crumme has no preclusive effect on this proceeding. We therefore proceed to the merits.

Impairment Values

On February 14, 1991, Dr. Slack examined claimant and made range of motion findings. (Ex. 63). However, review of his report indicates that he relied on the prior standards in reporting those findings. Moreover, he did not identify the measuring instrument he used to determine claimant's range of motion. Consequently, we cannot apply his findings to the March 12, 1992 standards which are applicable in this case. In contrast, Western Medical Consultants, using the inclinometer, determined claimant's loss range of motion. Applying these findings to the March 12, 1992 standards, we find claimant's low back impairment value due to loss range of motion is a total of 20.2 percent. This total value is then rounded to the nearest whole number, 20 percent. OAR 436-35-360(19) through OAR 436-35-360(21).

Claimant's impairment values due to surgeries is 9 percent for a L5-S1 laminectomy with discectomy performed on April 11, 1989, 2 percent for a November 8, 1989 L5-S1 laminectomy with discectomy, and 2 percent for a February 14, 1990 L5-S1 laminectomy with discectomy. Claimant is also allowed an additional 2 percent for a L5 and S1 facetectomy performed on February 14, 1990. These surgical values are added for a total of 15 percent. OAR 436-35-350(2).

The total range of motion loss, 20 percent, is combined with the total surgical value, 15 percent, for total low back impairment value of 32 percent. OAR 436-35-360(23).

The Referee also concluded that claimant was not entitled to a rating for his psychological condition because he found no impairment had been assigned or concurred in by Dr. Wayson. Claimant argues for a rating of 35 percent based on Dr. Dixon's February 1991 report which indicated that claimant's psychological condition was a psychoneurosis disorder. Both Dr. Parvaresh and clinical psychologist Morrell made findings regarding claimant's impairment. However, there is no evidence Dr. Wayson concurred in those findings. Dr. Dixon, on the other hand, also assessed claimant's psychological impairment and opined claimant had a psychoneurosis, which he estimated to be class 2 and moderate in gradation. (Ex. 66-5-8). Dr. Wayson specifically concurred with this finding. (Ex. 84-3). There is no contrary opinion. Therefore, in accordance with OAR 438-35-400(5)(b), claimant is entitled to an impairment value of 35 percent.

When claimant's low back and psychological impairment ratings are combined, claimant's total impairment value is 55.8 percent, rounded to 56 percent.

Age

The parties do not dispute that the value for age is 0.

Education

The parties also do not dispute that the value for formal education and skills is 3. However, on review, claimant seeks an additional value of 1 for training. We disagree.

OAR 436-35-300(5) provides that workers who do not hold a current license or certificate of completion necessary to obtain employer in an Oregon job that has an SVP of 4 or less, and who have not worked at a job with an SVP of 5 or higher in the ten years preceding the time of determination, shall be allowed an additional value of 1 for training.

Claimant has submitted no evidence which establishes that he is entitled to the additional value for training granted under this rule. Accordingly, we find claimant is not entitled to an additional value for training. OAR 436-35-300(5). Therefore, claimant's education value is 3.

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).

Claimant's job at injury as a tanker truck driver had a strength factor of medium. On July 14, 1992, claimant was examined by Western Medical Consultants. Based on a physical capacities evaluation, the panel opined that claimant could lift up to 40 pounds and would be able to stand most of an eight-hour shift provided claimant would have a reasonable opportunity to change his stance. (Ex. 78-3). Dr. Wayson concurred in this report. (Ex. 82). Based on this evidence, we find that claimant's residual functional capacity at the time of reconsideration was medium/light for a value of 2. OAR 436-35-310(3).

Having determined each of the values necessary under the standards, we calculate claimant's unscheduled permanent disability. The sum of the value (0) for claimant's age and the value (3) for education is (3). The product of that value and the value (2) for claimant's adaptability is (6). The sum of that product and the value (56) for claimant's impairment is (62). That value represents claimant's current unscheduled disability. OAR 436-35-280.

Application of ORS 656.214(5)

However, under ORS 656.214(5), if a claimant suffers from disability due to preexisting injuries and has received unscheduled permanent disability for such disability, the prior disability award is considered in arriving at the appropriate permanent disability for the current injury. See Mary A. Vogelaar, 42 Van Natta 2846 (1990). OAR 436-35-007(3)(b) further provides:

> "(b) A worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury but which had already been produced by an earlier injury and had been compensated by a prior award. Only that portion of such lost earning capacity which was not present prior to the current injury shall be awarded. The following factors shall be considered when determining the extent of current disability award:
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> "(A) The worker's total loss of earning capacity for the current disability under the standards;
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> "(B) The conditions or findings of impairment from prior awards which were still present just prior to the current claim;
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> "(C) The worker's social-vocational factors which were still present just prior to the current claim; and
>
> "(D) The extent to which the current loss of earning capacity includes impairment and social-vocational factors which existed before the current injury."

This determination requires a two-step process. First, we determine the current extent of disability under the applicable standards. We then compare this value with the prior award of unscheduled permanent disability to determine if the current award reflects any preexisting disability for which claimant received benefits.

Here, we have concluded that claimant's current unscheduled permanent disability for the low back and psychological condition is 62 percent. Previously, claimant was awarded 49 percent unscheduled permanent disability for the low back. (Exs. 71, 86). Therefore, in accordance with the administrative rule, we offset claimant's prior award against claimant's current unscheduled permanent disability as calculated by this order.

After taking into account whether and to what extent the prior unscheduled disability resulted from the same impairment and social/vocational factors as claimant's current permanent disability, we find that claimant's current disability as related to his low back condition has been considered and compensated in the previous 49 percent award. We further find, however, the previous award did not include claimant's psychological condition. Accordingly, inasmuch as claimant's prior award did not include claimant's psychological disability, claimant is entitled to an additional unscheduled award of 35 percent.

Scheduled Permanent Disability

Right Leg

The Referee calculated claimant's right leg disability at 10 percent based on loss of plantar sensation in the right foot and chronic right leg condition. Because claimant had previously been awarded 10 percent for right leg disability, the Referee declined to find that claimant was entitled to any further award for the right leg. On review, claimant seeks an award of 14 percent based on loss of plantar sensation in the right foot, chronic right foot condition, and chronic right leg condition.

Based upon his February 14, 1991 examination of claimant, Dr. Slack found loss of plantar sensation in the right foot, and a chronic condition limiting repetitive use of the right foot and right leg. (Ex. 63). These findings were concurred in by Dr. Wayson. (Ex. 84-3). On July 14, 1992, claimant was examined by a panel from Western Medical Consultants. They found no loss of sensation in the right foot. (Exs. 78, 81) Neither did the panel find a chronic condition. These findings were also concurred in by Dr. Wayson. (Exs. 78, 82).

ORS 656.283(7) requires that claimant's disability is be rated as of the time of reconsideration. Because the Western Medical Consultants examination was closer in time to the Order on Reconsideration than Dr. Slack's examination, we use the panel's findings, as adopted by Dr. Wayson, in determining claimant's right leg impairment. Alex J. Como, 44 Van Natta 221 (1992). Alternatively, since Dr. Wayson concurred in findings which were inconsistent, the record fails to establish claimant's entitlement to an additional award. Therefore, claimant is not entitled to any disability involving the right extremity.

Even assuming the evidence is adequate to conclude claimant has a chronic right foot and right leg condition, the standards allow for only one award of 5 percent for the body part (here the right leg) which results in the larger dollar amount of compensation to the injured worker. OAR 436-35-010(6)(b). That being the case, even assuming claimant is entitled to a value for loss of plantar sensation and chronic conditions, the combined result would be 10 percent. Accordingly, we find claimant is not entitled to any further disability award for the right leg.

Left Leg

The Referee calculated claimant's left leg disability at 5 percent based on loss of plantar sensation in the left foot. However, because claimant had previously been awarded 5 percent for left leg disability, the Referee declined to find that claimant was entitled to any further award. On review, claimant seeks an award of 14 percent based on loss of plantar sensation in the left foot, chronic left foot condition, and chronic left leg condition.

Based upon his February 14, 1991 examination of claimant, Dr. Slack found loss of plantar sensation in the left foot. Dr. Slack also opined that claimant had a chronic condition limiting repetitive use of the left foot and left leg. (Ex. 63). As previously noted, the Western Medical Consultants found no sensory loss in the lower extremities. (Ex. 78-2). Neither did they opine a chronic condition effecting the left foot or left leg.

For the reasons previously stated, we use the panel's findings, as adopted by Dr. Wayson, in determining claimant's left leg impairment as opposed to the findings of Dr. Slack. Alex J. Como, supra. In the alternative, since Dr. Wayson concurred in findings which were inconsistent, the record fails to establish claimant's entitlement to an additional award. Therefore, under the standards, claimant is not entitled to any further disability award involving the left extremity.

Attorney Fees

Inasmuch as claimant has been awarded an additional award of unscheduled permanent disability on this claim, claimant's counsel is entitled to an approved fee of 25 percent of the increased compensation created by this order, not to exceed $3,800. OAR 438-15-055(1).

ORDER

The Referee's order dated April 19, 1993 is modified. In addition to claimant's prior awards, claimant is granted an increased award of 35 percent (112 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award to date of 84 percent (268.8 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable by the insurer directly to claimant's attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
STEVEN L. CLINE, Claimant
WCB Case No. 93-00701
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of that portion of our January 26, 1994 Order on Review that affirmed Referee Black's order assessing a penalty under ORS 656.268(4)(g). SAIF argues that, subsequent to the parties' briefing in this case, we stated in Vena K. Mast, 46 Van Natta 34 (1994), that only the Department has statutory authority to impose a penalty under ORS 656.268(4)(g). Claimant has filed a response, arguing that ORS 656.268(4)(g) authorizes the Board to assess the penalty. In order to further consider SAIF's motion, we withdrew our prior order on February 17, 1994. After reconsidering this matter, we adhere to our prior order with the following supplementation.

ORS 656.268(4)(g) 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."

This statutory provision authorizes assessment of a penalty against an insurer or self-insured employer if, upon reconsideration of a notice of closure, the following two conditions are met: (1) the claimant is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the claimant for permanent disability. If the statutory requirements are met, the claimant is automatically entitled to the penalty, without regard to whether the carrier's action was reasonable. Kevin Northcut, 45 Van Natta 173 (1993).

Here, we find that both conditions were satisfied. SAIF's Notice of Closure awarded claimant 23 percent scheduled disability for the right thumb for a total amount of $3,367.20. The Order on Reconsideration awarded claimant 6 percent scheduled disability for the right hand and 42 percent for the right thumb, resulting in an increase of $5,526.60 in permanent disability benefits. Thus, claimant was found to be at least 20 percent permanently disabled, and the amount of claimant's permanent disability compensation was increased by more than 25 percent over the Notice of Closure award.[1] (See Exs. 15 and 19).

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[1] OAR 436-30-050(13) provides that, for purposes of assessing a penalty under ORS 656.268(4)(g), "a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled." This rule could be interpreted to imply that a claimant who is awarded scheduled permanent disability of 20 percent or more, but whose total award calculates to less than 64 degrees, is deemed not to be at least 20 percent disabled for purposes of assessing a penalty under ORS 656.268(4)(g). That interpretation, we believe, is not consistent with the unambiguous language of ORS 656.268(4)(g), which expressly applies to claimants who are found to be "at least 20 percent permanently disabled." Here, claimant was awarded more than 20 percent scheduled disability for the right thumb alone, yet his total award calculates to 29.16 degrees, far less than 64 degrees. Nonetheless, because claimant has satisfied the statutory minimum of "20 percent" permanent disability, we decline to interpret OAR 436-30-050(13) as a bar to the assessment of a penalty pursuant to the terms of ORS 656.268(4)(g).

Under the facts of this case, therefore, ORS 656.268(4)(g) requires the assessment of a penalty against SAIF. The question is whether or not the Board and its Hearings Division is authorized to assess the penalty. SAIF correctly points out that in Vena K. Mast, supra, we stated that "we lack authority to assess a penalty under ORS 656.268(4)(g)." However, in Mast, the claimant's permanent disability award had been reduced below the level for which a penalty may be assessed under ORS 656.268(4)(g). Thus, inasmuch as the claimant in Mast could not qualify for a penalty under the statute, the above-quoted statement concerning our general authority to assess a penalty under the statute was dicta.

We find no language in ORS 656.268(4)(g) which prohibits the Board or Hearings Division from assessing a penalty, if the aforementioned conditions have been met, nor is there any language which limits the penalty assessment authority to the Department. Rather, the statute is phrased broadly and does not specify that any particular body must assess the penalty; it merely requires that "a penalty shall be assessed." Absent any language in the statute which restricts the authority to assess a penalty to the Department, we decline to adopt SAIF's restrictive interpretation. Finally, insofar as Vena K. Mast could be interpreted to deny penalty assessment authority to the Board or Hearings Division, it is disavowed as an impermissible restriction on ORS 656.268(4)(g).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our January 26, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Members Gunn and Hall specially concurring.

By joining in the majority in this jurisdictional case, we do not change our position as expressed in the dissent in Vena K. Mast.

March 25, 1994 Cite as 46 Van Natta 513 (1994)

In the Matter of the Compensation of
WILLIAM M. PINARD, Claimant
WCB Case No. 93-04223
ORDER ON RECONSIDERATION (REMANDING)
Peter O. Hansen, Claimant Attorney
Carol Smith (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 10, 1994 Order on Review (Remanding). In that order, we concluded that the Hearings Division had jurisdiction over the parties' medical services dispute. Consequently, we remanded the case to Referee Galton for further proceedings to be conducted in any manner that would achieve substantial justice.

On reconsideration, SAIF suggests that there may be two separate disputes in this case: a medical fee dispute and a medical services dispute. SAIF notes that a medical fee dispute is not within the Hearing Division's jurisdiction and requests that we instruct Referee Galton that, if claimant is only contesting the hourly rate paid to his wife for performance of home health care services, then the case should be dismissed for lack of jurisdiction.

Our initial order did not instruct Referee Galton to consider matters outside of his jurisdiction. Instead, relying on Meyers v. Darigold, Inc., 123 Or App 217 (1993), a case decided subsequent to Referee Galton's order, we concluded that the Referee was authorized to consider the medical services dispute. In doing so, we did note that, at hearing, claimant's attorney clarified the issue as being a dispute regarding the hourly rate and amount of time paid to claimant's wife for her provision of home health care services.

Since SAIF is contending that the medical services dispute raised by claimant actually includes a medical fee dispute that is not within the Hearings Division's jurisdiction, SAIF is not precluded from asserting that argument to Referee Galton on remand. Likewise, Referee Galton is under no restriction

from addressing such a contention. As we stated in our initial order, Referee Galton may proceed in any manner that will achieve substantial justice. ORS 656.283(7). That necessarily includes determinations regarding whether certain issues are either within or outside of the Hearings Division's jurisdiction. Consequently, we adhere to our prior order.

Accordingly, we withdraw our March 10, 1994 order. On reconsideration, as supplemented herein, we republish our March 10, 1994 order in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL M. PRICE, Claimant
WCB Case No. 92-13799
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

On February 4, 1994, we abated our January 10, 1994 Order on Review which had affirmed a Referee's order which: (1) held that the SAIF Corporation did not "de facto" deny claimant's claim for palliative medical services by submitting the claim to the Board for disposition under the Board's Own Motion jurisdiction; and (2) declined to award an attorney fee pursuant to ORS 656.386(1). After further consideration of the matter, we issue the following order.

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

In Roy Hansen, 43 Van Natta 990 (1991), the Board rejected the contentions that are now being made by the dissent. After further consideration of this issue, we adhere to the rationale expressed by the Board in Roy Hansen, supra. See also Carl M. Price, on recon 44 Van Natta 978 (1992).

As we reasoned in Hansen, while ORS 656.278 was amended by the 1990 act, it continued to provide that the Board has own motion authority to award medical benefits for injuries occurring prior to January 1, 1966. Thus, our statutory authority concerning pre-1966 medical benefits has not been abolished.

Moreover, if the legislature intended to grant palliative care as a matter of right to those workers injured prior to January 1, 1966 (excepting those injured between August 5, 1959 and December 31, 1965) and determined to be permanently and totally disabled, it could have removed the Board's subject-matter jurisdiction to review claims for medical benefits for pre-1966 injuries. Id. Since, the legislature did not do so, we continue to hold that we retain jurisdiction over requests for pre-1966 medical benefits.

ORDER

The Referee's order dated April 22, 1993 is affirmed.

Board Member Hall dissenting.

The majority finds that the Referee did not have jurisdiction to consider claimant's request for palliative medical treatment on the basis that claimant was injured before January 1, 1966. Because I believe the 1990 amendments to ORS 656.245 granted palliative treatment to all workers found permanently and totally disabled, without regard to the date of injury, I dissent.

In Roy Hansen, 43 Van Natta 990 (1991), the Board found that the 1990 amendments did not grant lifetime medical rights for those claimants injured before January 1, 1966. Therefore, the Board concluded that medical service claims, for those workers injured before January 1, 1966, were solely within the Board's Own Motion jurisdiction under ORS 656.278(2) and not subject to ORS 656.245.

The Board relied on the Hansen rationale to also find that the 1990 amendments concerning palliative treatment for workers who have been found permanently and totally disabled do not apply to those workers injured before January 1, 1966 (excepting those injured between August 5, 1959 and December 31, 1965 and resulted in permanent total disability). See Carl M. Price, on recon 44 Van Natta 978 (1992).

Based on the following reasoning, I believe the 1990 legislature specifically granted the right to palliative treatment to workers found permanently and totally disabled, regardless of the date of injury, thereby removing those palliative care matters from the Board's Own Motion jurisdiction.

In 1990, the legislature amended ORS 656.245. In particular, the following language was added. "Notwithstanding paragraph (a) of this subsection, after a worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability. . ." (Emphasis added). In addition, the relevant enabling clause, Section 54(1) states: "this 1990 Act becomes operative July 1, 1990 and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing and arising on and after July 1, 1990, regardless of the date of injury." (Emphasis added). While the Act contained certain exceptions to the retroactive application of the amendments, the amendment to ORS 656.245 was not subject to any such exception. Simply stated, the amendment providing palliative care to permanently and totally disabled workers was not limited by date of injury.

The plain language of ORS 656.245(1)(b) indicates that palliative care is to be provided to a worker who is determined to have permanent total disability. The language does not make any distinction with regard to when the worker was injured. Under statutory construction principles, we look primarily to the text and context of the statute to discover the legislature's intent and we must adopt a construction that gives effect to every word of a statute, if possible. Boone v. Wright, 314 Or 135 (1992); ORS 174.010. If there were no other statutes dealing with medical services, clearly the text of ORS 656.245(1)(b) would require that workers found permanently and totally disabled receive palliative care.

Another principle of statutory construction is that we give effect to the more specific and more recently enacted provision. ORS 174.020; Bartz v. State of Oregon, 110 Or App 614, aff'd 314 Or 353 (1992). The amendment to ORS 656.245(1)(b) is a more recently enacted and more specific statute than ORS 656.278(2). ORS 656.278(2) gives the Board the discretion to authorize medical benefits for injuries occurring before January 1, 1966. That statute does not specify what type of treatment nor does it refer to a claimant's status (such as permanent total disability). By contrast, ORS 656.245(1)(b) specifically references palliative care for workers awarded permanent total disability.

We must also interpret different statutory sections on the same subject as consistent with and in harmony with each other. See Davis v. Wasco IED, 286 Or 261, 272 (1979). The interpretation of ORS 656.245 and 656.278 (offered in this dissent) is internally consistent. That is, the Board retains (after the 1990 amendments) Own Motion jurisdiction over medical claims for injuries before January 1, 1966, except in cases of palliative care for those determined to be permanently and totally disabled.

Contrary to the majority's reasoning, the legislature did not need to completely remove the Board's Own Motion subject matter jurisdiction to review medical benefit claims in order to reach the interpretation used in this dissent. After all, ORS 656.245(1)(b) addresses a relatively small class of claimants (those determined to be permanently and totally disabled) and addresses only palliative care for that class of claimants. Furthermore, there is a purpose (sheer claim management if nothing else) served in exempting those found permanently and totally disabled from having to submit their claims for palliative care to the Board, in light of the fact that permanently and totally disabled claimants do not (by definition) require curative medical treatment but do often require regular ongoing palliative (maintenance) medical care.

The Board's jurisdiction under ORS 656.278 remains intact and the exercise of that jurisdiction is compatible with the dissent's interpretation of ORS 656.245(1)(b). In granting palliative care to permanently and totally disabled workers, the legislature had no reason to completely remove the Board's jurisdiction over medical benefits as is suggested by the majority. ORS 656.245(1)(b), as interpreted in this dissent, can stand (compatibly and statutorily consistent) side by side with ORS 656.278.

Based on the clear language and specificity of ORS 656.245(1)(b), I conclude that the legislature removed palliative medical care for claimants with permanent total disability from the Board's discretionary authority under ORS 656.278(2). Therefore, I would disavow Hansen and Price to the extent they conflict with this conclusion.

March 25, 1994 Cite as 46 Van Natta 516 (1994)

In the Matter of the Compensation of
CLIFFORD L. RHODES, Claimant
WCB Case Nos. 92-16485, 92-14467, 93-00883, 92-16484 & 92-15728
ORDER ON REVIEW (REMANDING)
Whitehead & Klosterman, Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney
Moscato, et al., Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of those portions of Arbitrator Daughtry's order that: (1) set aside its denial of claimant's low back injury claim; and (2) upheld Sears & Roebuck's (Sears) denial of claimant's aggravation claim for the same condition. Sears cross-requests review of the Arbitrator's interim order denying its motion to preclude SAIF from arguing that Sears was responsible for claimant's low back condition. Sears also requests that a monetary adjustment between the parties be ordered pursuant to ORS 656.307. On review, the issues are the interim order, responsibility and monetary adjustments. Reviewing for questions of law under ORS 656.307, we remand.

Claimant sustained a compensable injury to his low back on November 29, 1989 while employed by Sears. Sears accepted a low back strain that was closed by Determination Order on September 29, 1990, with an award of 20 percent unscheduled permanent disability.

On August 11, 1992, Best Flagging Company, insured by SAIF, employed claimant as a flagger. Claimant experienced an exacerbation of back pain when a gust of wind caught the sign he was holding, twisting him around. Claimant filed a claim against SAIF that day, which was denied on November 6, 1992. SAIF also disclaimed responsibility, alleging that Sears was responsible for claimant's back condition. SAIF does not dispute that its disclaimer was untimely.

On November 11, 1992, claimant filed a claim against Sears which was denied on December 2, 1992. Sears denied both compensability and responsibility, but requested designation of a paying agent pursuant to ORS 656.307. On December 29, 1992, a ".307" order was entered.

Prior to hearing, Sears moved to preclude SAIF from arguing that it was responsible for claimant's back condition because SAIF did not timely disclaim responsibility as required by ORS 656.308. The Arbitrator denied Sears' motion, reasoning that all potentially responsible parties were joined to the proceedings under the .307 order. Therefore, notwithstanding its failure to timely comply with the disclaimer provisions of ORS 656.308(2), the Arbitrator held that SAIF was not precluded from asserting that Sears was responsible.

On the merits, the Arbitrator found that the August 11, 1992 incident was a "material contributing cause" of claimant's disability and need for medical treatment. The Arbitrator then shifted responsibility for claimant's low back condition from Sears to SAIF.

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 Jack W. Sanford, 45 Van Natta 52 (1993).

Sears contends that the Arbitrator made an error of law by holding that SAIF was not precluded from asserting that Sears was responsible for claimant's low back condition. We need not decide this issue, since we conclude that the Arbitrator applied an incorrect legal standard to decide the responsibility issue.[1]

The Arbitrator shifted responsibility for claimant's low back condition on the basis of a "material contributing cause" standard. Subsequent to the Arbitrator's decision, however, the Supreme Court issued its decision in SAIF v. Drews, 318 Or 1 (1993). The Court ruled that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). Thus, to establish a "new compensable injury" under ORS 656.308, Sears must now prove that the August 11, 1992 incident was the "major contributing cause" of his resultant need for treatment or disability.

Because the Arbitrator applied a "material contributing cause" test, we find that this claim was not analyzed under the applicable legal standard. Because we only review questions of law, we must remand for additional findings and a determination of which employer or carrier is responsible when the correct rule of law is applied. See ORS 656.307(2); Patsy B. Marty, 44 Van Natta 139 (1992).

ORDER

The Arbitrator's decision dated May 19, 1993 is vacated. This matter is remanded to Arbitrator Daughtry for further action consistent with this order.

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[1] On remand, the Arbitrator is further directed to consider the untimely disclaimer issue in light of Penny L. Hamrick, on recon 46 Van Natta 410 (1994) and Jon F. Wilson, 45 Van Natta 2362 (1993). Before addressing this issue, the Arbitrator may wish to consider further argument from the parties.

In the Matter of the Compensation of
DOUGLAS L. TYREE, Claimant
WCB Case No. 93-03679
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Garaventa's order that affirmed an Order on Reconsideration that awarded claimant 2 percent (3 degrees) scheduled permanent partial disability for loss of use or function of the right forearm (wrist). On review, the issue is extent of scheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

Dr. Straub, the surgeon who performed claimant's right carpal tunnel surgery, concurred with Dr. Woolpert's conclusion that there were no objective findings regarding claimant's left wrist.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" with the exception of the second paragraph on page 3 of the Referee's order, which is modified to read:

Dr. Straub, the surgeon who performed claimant's right carpal tunnel surgery and who followed claimant through recovery, opined that claimant had no impairment as a result of his right carpal tunnel syndrome. Dr. Straub also concurred with Dr. Woolpert's conclusion that there were no objective findings regarding claimant's left wrist, and he released claimant to regular work without restriction. The medical arbiter panel likewise specifically stated that there was no objective evidence that claimant was unable to use either hand repetitively due to a diagnosed chronic and permanent medical condition arising out of a compensable injury.

We also add the following supplementation.

Dr. Panum recommended that claimant avoid repetitive use of his hands at work. Claimant argues that this is evidence that he is permanently unable to use his hands repetitively. We disagree. E.g., Rae L. Holzapfel, 45 Van Natta 1748 (1993) (physician's recommendation that the claimant avoid repetitive work activities not sufficient to establish inability to use wrists repetitively).

ORDER

The Referee's order dated June 29, 1993 is affirmed.

In the Matter of the Compensation of
PHILIP G. MICHAEL, Claimant
WCB Case Nos. 92-03027 & 91-06037
ORDER ON REVIEW
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant, pro se, requests review of Referee Holtan's order that: (1) upheld the self-insured employer's "back-up" denial of his injury claim; (2) upheld the employer's "de facto" denial of his psychological condition; and (3) declined to award further unscheduled permanent disability. Claimant moves for remand for the admission of additional evidence not offered at hearing. The employer has moved to strike claimant's appellant's brief on the grounds that it contains evidence not in the record. On review, the issues are motion to strike, remand and compensability.

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

Motion to Strike

The employer moves to strike claimant's appellate briefs on two grounds. First, the employer moves to strike on the basis that the briefs contain evidence not in the record. Second, citing OAR 438-06-100, the employer also moves to strike claimant's briefs on the ground that the briefs were prepared by claimant's mother who is not an attorney. The cited rule encourages injured workers to be represented by attorneys in formal hearings, but does not expressly require that a brief submitted to the Board be authored by an attorney. We deny the motion to strike on both grounds; however, in conducting our review, we will not consider any evidence not already contained in the record.

Motion for Remand/New Hearing

In his brief, claimant seeks the admission of additional evidence not admitted at hearing. We treat the presentation of new evidence on appeal as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). Specifically, claimant has submitted a February 12, 1992 letter from Dr. Nash with his brief. In addition, claimant has submitted a letter from his uncle who claimant asserts witnessed his injury. Contending that his former attorney did not call his uncle as a witness at the hearing, claimant seeks a new hearing to allow his uncle to testify. Claimant also requests that we remand the case to a different referee.

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). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). In this regard, we consider the proferred evidence only for purposes of claimant's remand motion.

We conclude that claimant has not established that the evidence he has offered was not obtainable with due diligence at the time of the May 1992 hearing. Specifically, Dr. Nash's February 12, 1992 letter was authored prior to the May 1992 hearing. Claimant has made no showing that this letter was not obtainable at the time of hearing. Likewise, claimant has not shown that the testimony of his uncle could not have been obtained with due diligence at the time of hearing. As claimant notes in his brief, the possibility of taking his uncle's telephone testimony was discussed at hearing. However, this testimony was never offered. No objection was made to the closure of the record and there was no request for a continuance to obtain the testimony. Moreover, the testimony of claimant's uncle alone would not cause us to alter our decision concerning claimant's credibility. Accordingly, we deny the motion for remand.

Finally, claimant has requested remand before a different Referee. We deny the motion. A review of the record reveals nothing to suggest that the hearing was conducted in any manner other

than a manner that would achieve substantial justice to all parties. Furthermore, claimant has not complied with OAR 438-06-095. If claimant felt that the Referee was biased, he should have objected at hearing and requested a change of referee. See OAR 438-06-095(2); Virginia L. Baker, 44 Van Natta 217 (1992). OAR 438-06-095(2) provides:

> "Any party may request that the referee be removed from a case, on grounds of personal bias or conflict of interest, by filing with the presiding referee, promptly upon discovery of the alleged facts, an affidavit which sets forth in detail the matters believed to constitute the grounds for disqualification."

OAR 438-06-095(3) provides:

> "If, in the opinion of the presiding referee, the request for disqualification is filed with due diligence and the supporting affidavit is sufficient on its face, the presiding referee shall either disqualify the referee and assign another referee to the case or order a hearing on the allegations in the affidavit.

Here, the request for a change of Referee was not filed promptly or diligently. OAR 438-06-095(2) and (3). Under such circumstances, claimant is not entitled to a new hearing. Virginia L. Baker, supra.

ORDER

The Referee's order dated May 13, 1993 is affirmed.

March 28, 1994 Cite as 46 Van Natta 520 (1994)

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case Nos. 92-11012 & 92-10411
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our February 4, 1994 Order on Review that awarded an assessed attorney fee of $150 for claimant's counsel's services in obtaining a pre-hearing rescission of the SAIF Corporation's "de facto" denial of claimant's adhesive capsulitis condition. Contending that our attorney fee award does not provide adequate compensation for her counsel's efforts, claimant seeks a $750 attorney fee.

In order to further consider this matter and to give SAIF an opportunity to respond, we withdrew our February 4, 1994 order. Having received no timely response from SAIF, we proceed with our reconsideration.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that a reasonable fee for claimant's attorney's services concerning rescission of SAIF's "de facto" denial is $500. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

Accordingly, our February 4, 1994 order is withdrawn. On reconsideration, as modified herein, we adhere to and republish our prior order in its entirety, effective this date. 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
DANIEL L. KIBBEE, Claimant
WCB Case No. 93-07623
ORDER DENYING MOTION TO DISMISS
Bruce D. Smith, Claimant Attorney
Cowling & Heysell, Defense Attorneys

The self-insured employer has moved the Board for an order dismissing claimant's request for Board review on the ground that a copy of the request was not served on all parties to this proceeding. We deny the motion.

FINDINGS OF FACT

The Referee's order issued February 8, 1994. Parties to that order were claimant, his employer, and its claim administrator.

On March 9, 1994, the Board received claimant's request for review of the Referee's order. Included with that request was claimant's counsel's certification that copies of the request had been mailed on March 9, 1994 to the employer's claim administrator and its attorney.

On March 14, 1994, the Board mailed a computer-generated letter to all parties acknowledging the request.

CONCLUSIONS OF LAW

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

"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). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987). Likewise, in the absence of a showing of prejudice to an employer, timely service of a request for review on the employer's carrier fulfills the notice requirements of ORS 656.295(2). Nollen v. SAIF, supra; Daryl M. Britzius, 43 Van Natta 1269 (1991); Joan M. Carranza, 40 Van Natta 773 (1988).

Here, claimant's request for Board review included his counsel's certification that copies of the request were mailed to the employer's claim administrator and its attorney on March 9, 1994. This certification is unrebutted. In light of such circumstances, we conclude that notice of claimant's request for Board review was mailed within 30 days of the Referee's February 8, 1994 order to the employer's legal representatives. See OAR 438-05-046(2)(a), and (b); Franklin Jefferson, 42 Van Natta 509 (1990); Daryl M. Britzius, supra; Joan M. Carranza, supra.

Furthermore, no contention has been made that the employer has been prejudiced by not directly receiving a copy of claimant's request for review. In the absence of such a finding, we hold that claimant's timely service by mail upon the employer's claim administrator and attorney (persons or entities in privity with the employer) is adequate compliance with ORS 656.295(2). Argonaut Insurance v. King, supra, at page 851-52; Nollen v. SAIF, supra, at page 423; Daryl M. Britzius, supra; Joan M. Carranza, supra.

Accordingly, the self-insured employer's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

March 28, 1994 Cite as 46 Van Natta 522 (1994)

In the Matter of the Compensation of
ROBERT E. WOLFORD, Claimant
WCB Case No. 91-06988
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 24, 1994 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders, as well as those issues which are presently pending before us in WCB Case No. 93-04351 and before the Hearings Division in WCB Case No. 93-10502. Those portions of the agreement which pertain to the other Board case and the Hearings Division case have received Board and Referee approval.

We have approved those portions of the stipulation which pertain to the issues in this case, thereby fully and finally resolving this dispute, in lieu of all prior orders. In other words, as provided in the settlement, the insurer's July 1, 1991 aggravation denial is "reinstated and affirmed in [its] entirety."

In granting this approval, we wish to emphasize that, since our March 31, 1993 order in WCB Case No. 92-00297 has become final by operation of law, we are without authority to alter that decision. Therefore, our approval is limited to those portions of the agreement which pertain to the issues in WCB Case No. 93-04351 and this case. Nevertheless, if the parties mutually agree not to enforce our decision in WCB Case No. 92-00297 that is their prerogative.

Finally, we note that the settlement does not contain "the parties' acknowledgment that [the settlement's] reimbursement allocation complies with the reimbursement formula prescribed in ORS 656.313(4)(d)" as required by OAR 438-09-010(2)(g). In addition, the agreement lacks a list of medical service providers who shall receive reimbursement in accordance with the statute. Id.

In place of these provisions, the settlement states that the insurer has paid all medical bills it had received on and before January 11, 1994, the date the settlement terms were agreed upon. Inasmuch as no outstanding bills from medical service providers were in the insurer's possession on the "settlement date," there are no billings which require reimbursement under ORS 656.313(4)(c). In light of such circumstances, we interpret the parties' aforementioned statement as explaining why the "list" and "acknowledgment" requirements of OAR 438-09-010(2)(g) are not applicable to this particular settlement. Based on this explanation, we have approved the parties' settlement.

Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
NINA J. BUTLER, Claimant
WCB Case No. 93-03012
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nichols' order that: (1) denied claimant's motion to postpone the hearing; (2) denied claimant's request to continue the hearing in order to depose the medical arbiter; and (3) affirmed an Order on Reconsideration that did not award claimant any unscheduled permanent disability for a June 1992 neck and back injury. On review, the issues are postponement, evidence, and extent of unscheduled permanent disability.

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

Claimant first contends that, because the SAIF Corporation asserted that the extent of claimant's current permanent disability may have been due to previous claims with different employers, those prior employers must be joined in the proceeding. The dispute, however, did not concern the responsibility for claimant's current condition which may necessitate the joining of other potentially liable employers. Rather, the dispute concerns the extent of permanent disability due to SAIF's accepted injury. As the carrier responsible for claimant's current condition, SAIF is responsible for further processing of the claim, including the determination of permanent disability resulting from its claim. Even if SAIF establishes that no permanent disability is due under its claim, that finding would not shift responsibility for claimant's current condition from SAIF.

Moreover, OAR 438-06-065 provides for joinder only in those situations where a carrier is a party to a ".307" order or a carrier is alleging that it is responsible for claimant's condition. OAR 438-06-065(3)(a) and (b). As noted above, there was no dispute concerning the responsibility for claimant's condition; therefore, claimant was not entitled to joinder.

A Referee shall not postpone a hearing "except upon a finding of extraordinary circumstances beyond the control of the party requesting postponement." See OAR 438-06-081. Inasmuch as the dispute did not concern responsibility for claimant's current condition, we find no extraordinary circumstances that would justify postponement of the hearing. Accordingly, the Referee did not err in declining to grant claimant's request for a postponement.

Claimant next contends that the Referee erred in denying her request to continue the hearing in order to depose the medical arbiter. We disagree.

Inasmuch as ORS 656.268(6)(a) refers to "any medical arbiter report," the admissibility of a deposition of a medical arbiter is questionable. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993). We need not address this question, however, as the admissibility of such a deposition is not squarely before us.

A Referee may continue a hearing for any reason that would justify postponement under OAR 438-06-081. See OAR 438-06-091. As the language of OAR 438-06-091 is permissive, the authority to continue a hearing rests within the Referee's discretion. See Sue Belucci, 41 Van Natta 1890 (1989). Finally, 438-06-091(2) requires a showing of due diligence if it is necessary to continue a hearing for the opportunity to cross-examine on documentary medical evidence.

Here, claimant did not present any circumstances that might justify postponing the hearing. Moreover, Dr. Stanford, the medical arbiter, issued his initial report on February 3, 1993. (Ex. 41). He issued a supplemental report on February 25, 1993. (Ex. 43).[1] The hearing was not held until June 1,

[1] Although the supplemental report from Dr. Stanford was prepared after his initial medical arbiter report, it can still be considered as it is from the medical arbiter. See Lorenzo Orozco-Santoya, 46 Van Natta 150 (1994).

1993. Thus, claimant had approximately three months prior to the hearing to depose Dr. Stanford. Thus, claimant has not shown that further information from Dr. Stanford could not have been obtained with due diligence prior to the hearing. OAR 438-06-091(2). Under these circumstances, the Referee did not abuse her discretion in declining to continue the hearing for the deposition of the medical arbiter.

ORDER

The Referee's order dated June 16, 1993, is affirmed.

March 29, 1994 Cite as 46 Van Natta 524 (1994)

In the Matter of the Compensation of
BILLIE M. CROOKS, Claimant
WCB Case No. 93-01693
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee McCullough's order that upheld the self-insured employer's denial of claimant's bilateral hand condition. On review, the issue is compensability.

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

Claimant asserts that the major contributing cause of her bilateral carpal tunnel syndrome is her work activities. Claimant relies on the opinion of her treating physician, Dr. Karasek, neurologist, to establish compensability under the major contributing cause test.

With regard to causation, Dr. Karasek first stated that he was uncertain as to whether claimant's job caused her carpal tunnel syndrome, but that work activities probably "aggravated the carpal tunnel to the point of requiring treatment." (Ex. 9-3). He subsequently stated that, based on a description of claimant's job duties, her work was "a contributing cause for carpal tunnel syndrome." (Ex. 14). He further indicated that "job activities are a significant contributing cause of her carpal tunnel syndrome and are the major contributing cause of her need for treatment." (Id.) Finally, Dr. Karasek reported that claimant's job required "enough repetitive and stressful use of the hands to be associated with carpal tunnel syndrome" and, specifically, "carrying 5-gallon buckets and cleaning and stocking the exam rooms, as well as filling out paper work would be expected to significantly contribute to carpal tunnel syndrome." (Ex. 16).

Claimant concedes that, in order to prove compensability, she must show that work activities were the major contributing cause of her bilateral carpal tunnel syndrome. See ORS 656.802(2). As noted above, Dr. Karasek stated (among other things) that "job activities are a significant contributing cause of her carpal tunnel syndrome and are the major contributing cause of her need for treatment." In view of his statement in the same report that claimant's work was a contributing cause of claimant's condition, and his earlier statement that claimant's work "aggravated" her condition, we understand Dr. Karasek to indicate that claimant's work activities were one of the factors in causing her underlying condition, although it was the major cause of her symptoms. This construction is supported by Dr. Karasek's subsequent statement that claimant's work was the type "associated" with her condition and could "significantly contribute" to the condition.

Our understanding of Dr. Karasek's opinion is not free from substantial doubt because, like the Referee, we find his opinion on causation unclear and confusing. According to our interpretation of his opinion, Dr. Karasek did not state that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. The remaining opinions attribute the condition to non-work related factors. Consequently, we agree with the Referee that claimant has failed to carry her burden of proof.

ORDER

The Referee's order dated June 11, 1993, as reconsidered July 8, 1993, is affirmed.

In the Matter of the Compensation of
STEPHEN L. HALEY, Claimant
WCB Case No. 93-02522
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Menashe's order that: (1) affirmed an Order on Reconsideration which awarded 19 percent (60.8 degrees) unscheduled permanent disability for a low back injury; and (2) declined to award further temporary disability. On review, the issues are extent of scheduled and unscheduled permanent disability and temporary disability.

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

At the hearing, claimant challenged the adaptability factor used in the October 15, 1992 Order on Reconsideration.

Relying on our holding in Raymond L. Mackey, 45 Van Natta 776 (1993), the Referee held that, since claimant did not challenge the adaptability factor in his request for reconsideration, he was precluded from doing so at hearing. Subsequent to the Referee's order, the court issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In Smith, the court held that the claimant's adaptability must be determined on the basis of work status as of the date of the reconsideration order, rather than the date of the prior determination order. The Smith court determined that, pursuant to ORS 656.268(5), a referee may consider evidence at hearing that was not submitted on reconsideration.

Given the court's determination that the reconsideration and hearing levels constitute two distinct proceedings, we subsequently concluded that Mackey should no longer be given effect. See Darlene K. Bentley, 45 Van Natta 1719 (1993). In accordance with the Bentley rationale, we recently concluded that the parties may raise extent of permanent disability issues at hearing, regardless of whether those issues were specifically raised at the reconsideration proceeding. Bentley, supra; see also Ruth E. Griffin, 46 Van Natta 418 (1994).

Accordingly, we address claimant's contention that he is entitled to a higher adaptability factor.

We apply the standards in effect on the date of the September 10, 1992 Notice of Closure. (WCD Admin. Order 11-1992; 6-1992). Under the applicable standards, the adaptability factor is based on a comparison of the prior 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). Former OAR 436-35-270(3)(g) provides that prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury.

We consider the record as a whole, including the job duties and the physical demands of the relevant job, in determining which DOT is most applicable. Nevertheless, the fact remains that the most applicable DOT determines the strength category. See former OAR 436-35-270(3)(g); William D. Knox, 45 Van Natta 854 (1993). Claimant's testimony is relevant to the determination of which DOT most accurately describes his at-injury job. Kathyron D. Parsons, 45 Van Natta 954 (1993). However, claimant's testimony may not be relied upon to determine that no DOT description accurately describes his job, and that, therefore, his strength category must be determined without regard to the DOT. Id.

The Order on Reconsideration found that claimant's adaptability factor was 2. In determining claimant's adaptability, the Appellate Unit identified claimant's job at injury as carpenter, DOT 860-281-010, which has an SVP of 7 and is identified as a medium strength job. Claimant's maximum residual functional capacity was light/medium. (Exs. 11-5; 12; 15-1).

At hearing, claimant contended that his job at injury actually required him to perform very heavy work. As stated above, the strength requirement for claimant's job must be determined by the DOT job description. Claimant has not identified a particular DOT which describes his job more

accurately than the DOT used by the Appellate Unit. (Tr. 2). Moreover, we have not found a DOT job description that is more appropriate for claimant's work than as a carpenter, DOT 860.281-010. Accordingly, we conclude that the Order on Reconsideration correctly identified claimant's SVP and adaptability factor.

Claimant also sought a scheduled award for a chronic condition in his right leg pursuant to former OAR 436-35-010(6). That rule requires medical evidence of at least a partial loss of ability to repetitively use a body part. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993). Based on this record, we find no evidence that claimant has a partial loss of ability to repetitively use his right leg. Accordingly, no award of scheduled permanent disability is warranted.

ORDER

The Referee's order dated June 15, 1993 is affirmed.

March 29, 1994 Cite as 46 Van Natta 526 (1994)

In the Matter of the Compensation of
DAVID HILL, Claimant
WCB Case No. 93-04063
ORDER ON REVIEW
Ronald M. Somers, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that dismissed his request for hearing from an Order on Reconsideration as untimely. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

We take administrative notice of the following facts.

On September 9, 1992, a Determination Order issued awarding claimant 6 percent unscheduled permanent disability compensation and no temporary disability compensation.

On January 11, 1993, claimant requested reconsideration of the September 9, 1992 Determination Order. On April 5, 1993, claimant requested a hearing, raising issues of extent of unscheduled permanent disability, medical services, and premature claim closure.

On April 8, 1993, the Director issued an Order on Reconsideration that awarded claimant an additional 3 percent unscheduled permanent disability for a total award of 9 percent.

Claimant did not request a hearing subsequent to the issuance of the April 8, 1993 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Prior to convening a hearing, the Referee dismissed claimant's hearing request based on the insurer's motion to dismiss the request for the reason that claimant's appeal from the Determination Order had not been timely made. Although requesting Board review of the Referee's order, claimant's attorney submitted no brief on review. In any event, we agree that dismissal of the hearing request was appropriate.

No hearing was convened and no record was created. However, 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 and docketed appeals. See, e.g., Sandra R. Farrow, 45 Van Natta 1506 (1993); Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as the September 9, 1992 Determination Order, claimant's April 5, 1993 request for hearing, and the April 8, 1993 Order on Reconsideration meet the aforementioned standard, we take administrative notice of them.

In 1990, the legislature amended ORS 656.268 to establish a reconsideration process. The statutory language used to create this process clearly indicates that it is a mandatory process that must be completed prior to requesting a hearing on issues relating to the Determination Order or Notice of Closure. ORS 656.268(4)(e); 656.268(5); 656.268(6)(b); Lorna D. Hildebrand, 43 Van Natta 2721 (1991). In addition, the Hearings Division's review authority under ORS 656.268(6)(b) is expressly contingent on the issuance of a reconsideration order. Thus, we have held that the Hearings Division does not have jurisdiction to consider a request for hearing prior to the issuance of a reconsideration order. See Larry R. Hudnall, 44 Van Natta 2378 (1992).

Here, the hearing request was made prior to the issuance of a reconsideration order. Furthermore, claimant did not request a hearing subsequent to the issuance of the April 8, 1993 reconsideration order. Therefore, claimant did not request a hearing within the requisite 180 day appeal period. ORS 656.268(6)(b); Larry R. Hudnall, supra. Consequently, the Hearings Division was without authority to consider claimant's appeal.

ORDER

The Referee's order dated June 25, 1993 is affirmed.

March 29, 1994 Cite as 46 Van Natta 527 (1994)

In the Matter of the Compensation of
MELISSA B. MUNN, Claimant
WCB Case No. 93-05028
ORDER ON REVIEW
Beers, Zimmerman, et al., Claimant Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant, pro se, requests review of Referee Mongrain's order that dismissed claimant's request for hearing from an Order on Reconsideration as untimely filed. On review, the issue is whether the claimant requested a hearing within the 180-day period required by ORS 656.268(6)(b).

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

A Determination Order (DO) issued and was mailed on July 13, 1992. ORS 656.268(6)(b) provides that the 180-day period to seek a hearing begins to run from the date copies of the DO are mailed. Therefore, the 180-day period began July 13, 1992. Claimant requested reconsideration from the DO on January 7, 1993. Since the date of the DO and the date of the reconsideration request are not considered in calculating the 180-day period, 177 days had expired by the time claimant requested reconsideration.

The Order on Reconsideration issued and was mailed on March 19, 1993. ORS 656.268(6)(b) further provides that the time required to complete the reconsideration process and the date of the Order on Reconsideration are not considered in calculating the 180-day period to seek a hearing. After the Order on Reconsideration issued, however, the 180-day period again began to run.

Thus, claimant had until March 22, 1993 to file her request for hearing. Claimant's hearing request was dated April 23, 1993, and was received by the Board on April 26, 1993. Because claimant requested hearing more than 180 days after the date the DO was mailed, her hearing request was filed untimely. See ORS 656.268(6)(b).

ORDER

The Referee's order dated July 15, 1993 is affirmed.

In the Matter of the Compensation of
JOHN R. NOLAN, Claimant
WCB Case No. 93-03524
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Hoguet's order that assessed a 10 percent penalty for the the insurer's allegedly unreasonable claims processing. In his brief, claimant requests that the Referee's penalty assessment be increased to 25 percent. On review, the issue is penalties. We modify.

FINDINGS OF FACT

Claimant compensably injured his head and neck in 1989. His claim was closed by a December 1990 Notice of Closure that found him medically stationary in September 1990. (Ex. 44). An Order on Reconsideration issued on August 30, 1991. Claimant requested a hearing concerning the Order on Reconsideration and the de facto denial of his psychological condition.

On February 16, 1993, a prior referee found the psychological condition compensable. Concluding that claimant's psychological condition was not medically stationary on the date of closure, he set aside the Notice of Closure and Order on Reconsideration as premature. (Ex. 66A). The insurer requested review of the prior referee's order. On March 11, 1994, we affirmed the order. John R. Nolan, 46 Van Natta 434 (1994).

The insurer failed to pay temporary disability benefits that accrued from the date of the prior referee's order.

CONCLUSIONS OF LAW AND OPINION

Penalties

The Referee held that the insurer's failure to pay temporary disability compensation that accrued from the date ofthe February 16, 1993 Opinion and Order was unreasonable. The Referee assessed a 10 percent penalty based on his findings that claimant was medically stationary as to the physical component of his claim in September 1990, that claimant's psychological condition has never been disabling, and that claimant has not seriously sought work. (O&O at 3).

Claimant contends that the penalty should be increased to 25 percent, inasmuch as none of the reasons for mitigation cited by the Referee provides a basis for failure to pay the stayed compensation. We agree.

By Opinion and Order dated February 16, 1993, the prior referee concluded that claimant had a compensable psychological condition since early January 1990 and that claimant has not yet become medically stationary. The prior referee set aside the Notice of Closure as premature. A subsequent Board order affirmed this order. John R. Nolan, supra.

Here, the insurer argues that claimant was never substantively entitled to temporary disability benefits because his psychological condition was not disabling at the time of the prior order and that claimant had been working in the home without making serious efforts to find other employment. Yet, these arguments are issues to be raised in evaluating claimant's substantive entitlement to temporary disability benefits. Because claimant's claim had not been closed at the time of the June 11, 1993 hearing, the issue of claimant's substantive entitlement to temporary disability benefits was not ripe for adjudication. Consequently, the Referee's findings were premature and do not provide justification for the insurer's failure to pay the stayed compensation.

Filing by an employer or insurer of a request for hearing, Board review or court appeal stays payment of the compensation appealed, except for temporary disability benefits that accrue from the

date of the order appealed from until closure, or until the order is reversed, whichever event occurs first. ORS 656.313(1)(a)(A); Lela K. Mead-Johnson, 45 Van Natta 1754 (1993); Steven S. Ewen, 45 Van Natta 207, on recon 45 Van Natta 425 (1993). Thus, the insurer was obligated to make temporary disability payments from February 16, 1993, (the date of the appealed Referee's order) until claim closure or reversal of the February 16, 1993 order.

We conclude that a penalty of 25 percent of the amounts due at the time of the June 11, 1993 hearing in this case is appropriate, with one-half of this amount payable to claimant's attorney in lieu of an attorney fee. See ORS 656.262(10).

ORDER

The Referee's order dated June 25, 1993 is modified in part and affirmed in part. That portion of the order that assessed a penalty of 10 percent is modified to increase the penalty to 25 percent. One-half of this amount shall be paid by the insurer directly to claimant's attorney. The remainder of the order is affirmed.

March 30, 1994 Cite as 46 Van Natta 529 (1994)

In the Matter of the Compensation of
DAVID B. BENNETT, Claimant
WCB Case No. 93-00561
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Neal's order that upheld the SAIF Corporation's "de facto" denial of his injury claim for a compression deformity of the thoracic and lumbar spines. In his brief, claimant objects to the Referee's evidentiary ruling which excluded proposed Exhibit 22A. On review, the issues are compensability and evidence.

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

Evidence

The Referee excluded proposed Exhibit 22A from the record on the basis that it was not relevant to the compensability issue. On review, claimant contends that the exhibit is relevant evidence concerning the compensability of claimant's spinal condition.

ORS 656.283(7) provides that the referee is not bound by common law or statutory rules of evidence * * * and may conduct a hearing in any manner that will achieve substantial justice. The statute has been interpreted as giving referees broad discretion with regard to the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee's evidentiary rulings for abuse of discretion. Evan I. Lyman, II, 45 Van Natta 2301 (1993); William J. Bos, 44 Van Natta 1691 (1992).

Proposed Exhibit 22A is SAIF's calculation of the reserves that it should set aside to cover the potential future costs of claimant's claim. Claimant argues that since the reserve analysis takes into account possible treatment for claimant's spinal condition, SAIF has admitted that this condition is compensable. On this basis, claimant contends that the exhibit is relevant to the compensability issue.[1] We disagree.

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[1] Member Gunn might find such a document an aid to determining value to claimant in an attorney fee dispute.

We do not find SAIF's calculation of its possible future liability for claimant's claim to be particularly relevant to whether or not claimant has a spinal condition which is compensable. The reserve calculation is different from a medical report which diagnoses a spinal condition and addresses the relationship of the compensable injury to the spinal condition. The reserve analysis is merely an estimate of the possible future liability for the claim. It does not establish that the spinal condition is compensable. Thus, we conclude that the Referee did not abuse her discretion in declining to admit proposed Exhibit 22A.

Compensability

Reasoning that claimant first complained about back pain several months after his injury, the Referee concluded that claimant's spinal condition should be analyzed as a consequence of his compensable injury. Therefore, the Referee concluded that claimant had the burden to prove that his industrial injury was the major contributing cause of his disability or need for treatment.

A condition that arises belatedly is not necessarily a "consequential" condition. See Virgil A. Ray, 45 Van Natta 1085 (1993). The key inquiry is whether the condition or need for treatment is caused directly by the industrial accident or whether it is caused in turn by the compensable injury. ORS 656.005(7); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992); John G. Davison, Dcd, 45 Van Natta 389 (1993), aff'd Davison v. McDonnald & Weltel, 125 Or App 338 (1993).

Since we conclude that claimant has not established that his compensable injury is even a material contributing cause of a spinal compression deformity, it is unnecessary for us to determine which standard is applicable. As noted by the Referee, the record does not even establish the existence of a compression deformity of the spine. Two physicians address the possibility of a compression deformity of claimant's spine. Dr. Gambee examined claimant on behalf of SAIF. He diagnosed "possible compression fractures at the dorsolumbar junction." Addressing the extent of claimant's permanent disability, Dr. Gambee stated: "He does have permanent disability in his lumbar spine because of the compression deformities that are presumed to be due to this injury." (Ex. 21-3, emphasis added). Dr. Berselli, claimant's attending physician, concurred with Dr. Gambee's report. (Ex. 23). Dr. Berselli later indicated that claimant had no evidence of any sort of spinal fracture. (Ex. 29).

Based upon the medical record, we conclude that it is doubtful whether claimant even has a compression deformity/fracture. Furthermore, we find Dr. Gambee's statement that the compression deformities were "presumed" to be due to the injury insufficient to establish that the deformities were related to the compensable injury by a reasonable medical probability. Thus, we agree with the Referee that claimant has failed to establish that he has a compensable spinal condition.

ORDER

The Referee's order dated June 1, 1993 is affirmed.

In the Matter of the Compensation of
BRIAN A. BUNDY, Claimant
WCB Case No. 93-00813
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Moscato, et al., Defense Attorneys

Claimant requests reconsideration of our March 9, 1994 Order on Review that set aside the self-insured employer's denial of claimant's occupational disease claim for an unstable L5-S1 spondylolisthesis condition. Specifically, claimant reiterates that he is entitled to temporary disability benefits because his 1991 aggravation claim was prematurely closed or, alternatively, because he became disabled as of the date his physician requested authorization to perform surgery. Having received the self-insured employer's response, we proceed with our reconsideration.

After reviewing the record, our prior order and the parties' arguments on reconsideration, we continue to conclude that claimant has not proven that the 1991 aggravation claim (which followed a 1989 compensable lifting injury) was prematurely closed. In addition, we continue to conclude that claimant has not established that the 1989 injury claim should be reopened. Under these circumstances, claimant has not established entitlement to temporary disability benefits under the 1989 injury claim. Rather, for the reasons expressed in our decision, we are persuaded that claimant's current condition represents a compensable occupational disease claim.

In our Order on Review, we stated, "because no physician has authorized time loss since claimant's prior claim was properly closed, claimant has not established entitlement to temporary disability compensation under his current low back claim." (Order on Review, p. 5). Our reference to the "current low back claim" may have misled claimant. We meant to convey that claimant has not proven that his injury-related condition caused reimbursable time loss since the injury-related aggravation claim was properly closed on July 21, 1992.

Nonetheless, we reiterate that claimant has established a compensable "new" occupational disease (diagnosed as unstable L5-S1 spondylolisthesis), which is not the same condition as the 1989 accepted low back strain. In this regard, our order expressly set aside the employer's denial of claimant's occupational disease claim for an unstable L5-S1 spondylolisthesis condition and remanded that claim "for processing according to law." (Id.) Consistent with this directive, as well as its statutory obligations, the employer must determine whether claimant is entitled to temporary disability under his occupational disease claim and, if so, when such entitlement arises.

In other words, our order should not be interpreted as a decision regarding whether claimant is or is not entitled to such temporary disability benefits. Instead, our order was confined to the issues of premature closure, aggravation under the 1989 injury claim (including temporary disability flowing from such a "claim reopening"), and occupational disease. Since claimant's entitlement to temporary disability under the occupational disease claim does not arise until our decision setting the employer's denial aside, it would be premature for use to address this processing issue. Consequently, we leave that question to the parties as the employer begins to process claimant's occupational disease claim in accordance with our order.

Accordingly, we withdraw our March 9, 1994 order. On reconsideration, as supplemented herein, we republish our March 9, 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
AMALIA C. CHACON, Claimant
WCB Case No. 92-07794
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Daughtry's order that declared null and void the Determination Order/Order on Reconsideration that reduced claimant's unscheduled permanent disability award for a low back injury from 27 percent (86.4 degrees), as awarded by a previous Determination Order, to 9 percent (28.8 degrees). On review, the issue is extent of unscheduled permanent disability.

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

We begin with a brief summary of the facts. Claimant sustained a compensable low back injury in August 1990. The claim was accepted and closed by Determination Order on June 7, 1991, with an award of 27 percent unscheduled permanent disability. The award was based, in part, on the finding that claimant was unable to perform her regular work. No request for reconsideration was filed from the June 1991 Determination Order.

On November 18, 1991, SAIF filed a request for reduction of the previous award with the Evaluations Section of the Department of Insurance and Finance (since renamed the Department of Consumer and Business Services). See ORS 656.325(3). At the time of SAIF's request, the 180-day period for requesting reconsideration from the June 7, 1991 Determination Order had not yet expired. See ORS 656.268. SAIF's request was based on attending physician Dr. Nelson's September 1, 1991 release for claimant to perform her regular job. Pursuant to SAIF's request, the Department issued a Determination Order on November 29, 1991, that reduced claimant's unscheduled permanent disability award to 9 percent. Claimant requested reconsideration of that Determination Order. By Order on Reconsideration dated June 2, 1992, the Department affirmed the Determination Order.

Claimant requested a hearing, seeking reinstatement of the June 1991 Determination Order award. SAIF filed a cross-request for authorization of an offset for overpaid permanent partial disability compensation resulting from the reduced award.

The Referee declared void the November 29, 1991 Determination Order and the June 2, 1992 Order on Reconsideration, reasoning that SAIF could not seek redetermination of the June 7, 1991 Determination Order award unless it first requested reconsideration of that award by the Department pursuant to ORS 656.268. We agree.

The applicable statute is ORS 656.325(3), which provides:

> "A worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268."[1] (Emphasis supplied.)

This provision grants carriers the right to seek redetermination of a prior award by the Department when there is medical or other evidence that an injured worker's condition has improved. See Bentley v. SAIF, 38 Or App 473, 477 (1979).

By its terms, ORS 656.325(3) requires that adjustments in an award be made "in conformity with ORS 656.268." ORS 656.268 sets forth procedures for determining and directly appealing permanent disability awards. However, the redetermination procedure is not a direct appeal from a permanent disability award; rather, it is used to reduce an award after the right of direct appeal has expired.

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[1] The procedures for seeking redetermination of a prior award pursuant to ORS 656.325(3) are set forth in OAR 436-30-066.

The Court of Appeals explained in Bentley v. SAIF, supra:

> "The thrust of ORS 656.325(3) is that a worker's compensation should be reduced in the event his disability has reduced. This procedure does not, however, allow a reduction in the award unless there has been a decrease in disability. It is not simply an additional appeal right from the original award. * * * * Since the injured worker has a continuing obligation to reduce his disability and the award is subject to periodic examination and adjustment there is no time limit on the insurer's or employer's right to seek reduction of the award based on improvement in the worker's condition. If the appeal period following an award has not run the [carrier] may seek a hearing * * *. If the appeal time has run there is no right of the [carrier] to request a hearing and it must proceed under ORS 656.325 by seeking redetermination of the award." 38 Or App at 477-78. (Emphases supplied).

The Bentley court did not explicitly hold that a carrier must exhaust its direct appeal right before invoking the redetermination procedure. Nevertheless, it is apparent that the Bentley court viewed the redetermination procedure as a means of reducing an award which has already become final. That interpretation, we believe, best "conforms" the redetermination procedure with the direct appeal procedures in ORS 656.268.

ORS 656.268 was amended in 1990, subsequent to the Bentley decision. As amended, ORS 656.268(5) provides:

> "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."

Under this provision, the reconsideration procedure is the initial, mandatory step for objecting to a determination order. Here, SAIF objected to the June 1991 Determination Order based on post-closure evidence that claimant had been released for regular work. Inasmuch as the 180-day appeal period had not yet expired at the time SAIF received that evidence, we find that SAIF had ample opportunity to request reconsideration of the Determination Order under ORS 656.268(5). Yet, it failed to do so, opting instead to seek redetermination of the award under ORS 656.325(3). In doing so, SAIF circumvented the mandatory reconsideration procedure, in violation of ORS 656.268(5).

Because SAIF failed to conform to the terms of ORS 656.268, it was not authorized to seek a redetermination of claimant's award under ORS 656.325(3). Accordingly, the Referee properly declared null and void the November 29, 1991 Determination Order and June 2, 1992 Order on Reconsideration.

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 $660, 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 and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 13, 1992 is affirmed. Claimant's attorney is awarded $660 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
SONJA M. DAIRY, Claimant
WCB Case No. 93-03928
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the SAIF Corporation's "back-up" denial of claimant's low back and right hip injury claim. Claimant moves for remand for admission of evidence of the criminal record of one of SAIF's impeachment witnesses. On review, the issues are remand, the propriety of SAIF's "back-up" denial, and compensability. We deny the motion and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant argues that this case should be remanded for admission of two criminal conviction reports regarding SAIF's impeachment witness, Tommy Seiber. She argues that, because Mr. Seiber's name was not disclosed to her before hearing and because Mr. Seiber testified that he had never been convicted of any crimes, remand is warranted. We disagree.

We may remand a case to the Referee for further evidence taking if we find that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, the moving party must establish, inter alia, that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

The hearing in this matter convened on June 15, 1993. At hearing, claimant testified that she injured her back and right hip during a work-related accident. SAIF offered the testimony of Mr. Seiber, who stated that claimant had told him that the accident never occurred. On cross-examination, claimant's counsel asked, "Okay, have you been convicted of any crimes?" (Tr. 48). Mr. Seiber answered, "No." (Id.) After Seiber completed his testimony, SAIF indicated that it might recall him as a rebuttal witness after claimant testified. (Tr. 65).

Later, during cross-examination of claimant, SAIF's counsel asked claimant if she had ever been convicted of a crime. (Tr. 83). Claimant initially answered, "yes," but then testified, "I wasn't convicted. I put in a plea of no contest." (Tr. 83, 84). The Referee admitted a judgment from claimant's plea of no contest to the offense of initiating a false report. (Ex. 16). SAIF's counsel argued that, under Oregon law, a no contest plea is tantamount to a conviction, for purposes of impeachment. (Tr. 91-92). Claimant's counsel questioned the legal effect of a no contest plea. (Tr. 92). Thereafter, SAIF's counsel cited to ORS 135.345, which provides that "[a] judgment following entry of a no contest plea is a conviction of the offense to which the plea is entered."

The Referee found Mr. Seiber, based on demeanor, to be a credible witness. On the basis of Mr. Seiber's testimony, and claimant's no contest plea regarding the false report offense, the Referee found claimant not credible, and, therefore, gave her testimony minimal, if any, weight.[1]

Sometime after hearing, claimant's counsel discovered that, in February 1990 and on June 8, 1993 (seven days before this hearing), Mr. Seiber had pleaded no contest to charges of misdemeanor theft. Claimant seeks remand for admission of a case register that reflects Mr. Seiber's conviction for the 1990 charge on a plea of no contest,[2] and a June 8, 1993 judgment of conviction regarding the latter charge.

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[1] The Referee also found SAIF's other witness, Teresa Sarris, not credible, in light of impeaching documentary evidence and the testimony of Mr. Seiber. Ms. Sarris is Mr. Seiber's mother.

[2] The case register is dated July 6, 1993.

On this record, we conclude that remand is not warranted. We find that, in this case, due diligence required that claimant probe at hearing the veracity of Mr. Seiber's denial of any criminal convictions. The record reflects some confusion regarding whether a no contest plea is a conviction. Under the circumstances, we conclude that it was incumbent upon claimant to ascertain whether Mr. Seiber was similarly confused, such as by requesting that he be recalled for inquiry regarding whether he had ever pleaded no contest to a criminal charge.[3]

Alternatively, although claimant was not aware that SAIF would call Mr. Seiber as a witness until the day of hearing, we find that, because the evidence regarding Mr. Seiber's criminal record was in existence before hearing, it was obtainable with due diligence at the time of hearing. Such evidence could have been obtained by further cross-examination at hearing or production of the documentation regarding Mr. Seiber's criminal record prior to closure of the record. Since claimant neglected to avail herself of these opportunities at the time of hearing, we conclude that remand is not justified.

In sum, we are not convinced that evidence of Mr. Seiber's criminal convictions was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser, supra. Accordingly, we deny claimant's request for remand and proceed with our review.

Propriety of "Back-up" Denial

We adopt the Referee's conclusions regarding the propriety of SAIF's "back-up" denial, with the following supplementation.

A "back-up" denial is permissible if the insurer establishes by a preponderance of the evidence that its acceptance was induced by fraud, misrepresentation or other illegal activity. Tony N. Bard, 45 Van Natta 1225 (1993) (citing Bauman v. SAIF, 295 Or 788 (1983)). If the insurer meets that burden, the burden then shifts to the claimant to establish that the claim is, in fact, compensable. Parker v. North Pacific Ins. Co., 73 Or App 790 (1985).

We agree with the Referee that the insurer has established, by more than a preponderance of the evidence, that its acceptance was induced by claimant's misrepresentations. Accordingly, we affirm the Referee's decision to uphold SAIF's "back-up" denial. It now becomes claimant's burden to establish the compensability of her claim by a preponderance of the evidence. Tony N. Bard, supra, 45 Van Natta at 1227; see Parker v. North Pacific Ins. Co., supra.

Compensability

We adopt the Referee's conclusions regarding compensability.

ORDER

The Referee's order dated June 25, 1993 is affirmed.

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[3] In reaching this conclusion, we distinguish Robert D. Blanchfield, Jr., 44 Van Natta 2139, on recon 44 Van Natta 2276 (1992) and Jose L. Cervantes, 41 Van Natta 2419 (1989). In Blanchfield, we remanded a case in which a witness recanted his testimony after hearing, on the ground that he had been confused and did not properly remember the facts to which he had testified. In Cervantes, we remanded a case after evidence came to light that the claimant had lied during the hearing about whether he had participated in a fight.

Blanchfield is inapposite because the evidence that prompted remand -- a retraction of testimony -- did not even come into existence until after hearing. Here, we are not persuaded that evidence concerning Mr. Seiber's conviction reports were unobtainable in the exercise of due diligence before closure of the record.

Cervantes is likewise not on point because the evidence that was the subject of remand consisted of claimant's version of a certain event, the falsity of which could have been obtained at hearing only by forcing the claimant to admit that he had lied. Here, the veracity of Mr. Seiber's denial of any criminal convictions could have been tested either by clarifying at hearing whether Mr. Seiber had ever pleaded no contest to a criminal charge or by obtaining the records that claimant submits on review before the record was closed.

In the Matter of the Compensation of
ELDON A. HAWLEY, Claimant
Own Motion No. 92-0197M
OWN MOTION ORDER ON RECONSIDERATION
Susak, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requested reconsideration of our January 26, 1994 Own Motion Order in which we reopened claimant's 1977 claim to provide temporary disability compensation. On February 9, 1994, in order to fully consider the matter, we abated our prior order and granted claimant an opportunity to respond. After receiving claimant's response, and further considering the matter, we issue the following order.

In our January 26, 1994 order, we found that claimant had sustained a worsening of his compensable condition for which surgery had been requested. The proposed surgery was requested by Dr. Gehling in February 1992. In addition, we found that claimant was in the work force at the time of his worsening. Finally, we noted that SAIF's denial of claimant's current condition had been set aside by Referee Barber and that Referee Barber's order had been affirmed by the Board. Consequently, we authorized the payment of temporary disability benefits beginning the date that claimant was hospitalized for surgery.

Thereafter, SAIF requested reconsideration of our January 26, 1994 order, asserting that claimant was not entitled to temporary disability benefits on the basis that he had not undergone surgery. With its request, SAIF submitted a July 1, 1993 report from Dr. Boyd which indicated that claimant was medically stationary and released for regular work. Claimant responded to SAIF's request contending that he was still waiting for SAIF to approve the surgery authorization requested by Dr. Gehling in February 1992 and Dr. Boyd in March 1992. Claimant also noted that Referee Barber found that claimant's need for surgery was related to the compensable injury.

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 only authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Here, Drs. Gehling and Boyd recommended surgery in early 1992. The only medical report in the record since that time is a July 1, 1993 report from Dr. Boyd. That report does not indicate that surgery is still being contemplated and in fact, Dr. Boyd reported that claimant was released for regular work. Given the length of time that has passed since the original surgery recommendation, and in light of the absence of a medical opinion recommending surgery since that time, it appears that no surgery or other treatment requiring hospitalization is currently recommended by Dr. Boyd. Consequently, we cannot authorize the payment of temporary disability benefits at this time. ORS 656.278(1)(a).

In reaching this conclusion, we note that by virtue of Referee Barber's order and the Board's subsequent affirmance of that order, SAIF remains responsible for claimant's current neck condition and need for treatment. Should claimant require the proposed surgery at a future time, he may request reopening of his claim to provide temporary disability compensation at that time.

Accordingly, the request for own motion relief is denied. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT P. HOLLOWAY, SR., Claimant
WCB Case No. 90-21819
ORDER ON REVIEW
Tooze, Shenker, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband, and Hall.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order that: (1) awarded a $15,496.25 attorney fee pursuant to ORS 656.386(1) for claimant's prevailing over SAIF's denial of claimant's injury claim without a hearing; and (2) assessed a penalty and related attorney fee for allegedly unreasonable claim processing. Claimant cross-requests review, contending that, in the event that the Referee's order is reversed and/or remanded, the record should be further developed. On review, the issues are remand, penalties, and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Attorney fee pursuant to ORS 656.386(1)

The Referee awarded claimant's counsel an assessed attorney fee of $15,496.25 for counsel's efforts in causing the rescission of SAIF's November 26, 1990 denial prior to hearing. ORS 656.386(1). On review, SAIF contends that the fee awarded by the Referee was excessive, and suggests that a more reasonable fee would be approximately $2,500.

In determining a reasonable attorney fee under ORS 656.386(1), we consider the factors recited in OAR 438-15-010(4). Those factors are as follows: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (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.

Claimant's hearing request involved compensability of multiple injuries, including a head injury, arising out of a September 28, 1990 motor vehicle accident which was denied by SAIF on November 26, 1990. The basis for the denial was that claimant's injuries did not arise out of the course and scope of claimant's employment as a city police officer.

Due to the accident, claimant had retrograde amnesia. Therefore, he had no personal knowledge of the events leading up to the accident. As a result, claimant's counsel was required to independently investigate the facts without meaningful assistance from his client. (Tr. 70-71).

Consequently, claimant's counsel devoted a significant amount of time to the case and included three lay depositions that were held at the employer's place of business in Philomath. (See Exs. 18 (40 pages); 19 (7 pages); 20 (82 pages)). Counsel also was required to participate in several conference calls with referees addressing procedural matters pertaining to postponements, discovery, and evidence issues. Finally, inasmuch as the case was settled on May 22, 1991, but the hearing was scheduled for May 24, 1991, counsel was required to substantially prepare for trial. This included preparing for and subpoenaing 10 witnesses. (Tr. 92).

The Referee found that claimant's counsel's law firm rendered the following legal services: (1) claimant's counsel - 70.6 hours; (2) partner attorneys - 6.3 hours; (3) associate attorney - .2 hour; (4) law clerk - 9 hours; and (5) legal assistants - 53.6 hours. (Claimant's respondent's brief at page 3). Based on these hours and the various individual billing rates, the Referee estimated claimant's counsel's firm billing at $12,397.

The record contains what claimant's counsel has characterized as a "pre-bill." (Ex. 48; Tr. 63). The "pre-bill" itemizes various legal services and expenses from claimant's counsel's firm pertaining to claimant's case. Claimant's counsel testified, however, that some of the itemizations related to a collateral, but unrelated, disciplinary matter involving claimant. (Tr. 95, 116-117).

Claimant's counsel testified that in his opinion a reasonable attorney fee in this matter would be in the range of $15,000 to $20,000. (Tr. 96-97). In arriving at this range, counsel testified that he considered the factors listed in OAR 438-15-010(4).

In contrast to this testimony, SAIF offered the testimony of an expert witness, Mr. Kropp. Mr. Kropp testified that presently 65 percent of his attorney practice involves representing claimants in workers' compensation matters. He further testified that he has tried from 100 to 300 workers' compensation cases each year for the last 29 years. (Tr. 154-155). Based on his extensive experience representing injured workers, Mr. Kropp reached the following conclusions: (1) the case should have taken approximately 30 to 35 hours of attorney time; (2) claimant's counsel's billable rate of $115 an hour was reasonable; and (3) "staff time" should not have exceeded $1,000. (Tr. 159-171). In addition, he indicated that in a very similar case, but one that had gone to trial, he had obtained a fee of $7,500. (Tr. 167).

Finally, the record contains a March 21, 1991 letter which indicates that claimant's counsel's "bottom line" on a reasonable attorney fee was $8,300. This figure was based on actual hours expended by attorneys and legal assistants at their usual and customary rate with no inflation factor. (Ex. 31). Although admitted at hearing without objection, the parties urged the Referee to give little or no weight to the "amounts" listed inasmuch as the letter was written in the context of settlement negotiations. (Tr. 85-87). Accordingly, we likewise do not accord the representations in claimant's counsel's letter much probative weight.

Based on the above findings and evidence, we reach the following conclusions. The issues in dispute involved factually complex matters due to claimant's inability to remember crucial events. This added a unique burden on claimant's counsel.

The value of this claim is substantial in that as a result of the motor vehicle accident claimant sustained multiple injuries requiring two surgeries. Likewise, the benefit secured for claimant is significant in that he will be receiving compensation for these conditions and treatments. According to SAIF's claim examiner, the potential value of the claim, that is, future anticipated costs such as medical expenses, temporary disability, and permanent disability, is $86,740. (Tr. 39-43; Ex. 52).

Both parties were represented by skilled counsel. Moreover, we note both parties were zealous advocates for their respective clients. Finally, we take into account the risk that claimant's counsel's efforts might have gone uncompensated in this matter.

After conducting our review of this matter, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing concerning the compensability issue in question is $9,500. OAR 438-15-010(4). In reaching this conclusion, we take particular note that the efforts expended by claimant's counsel and the results secured for claimant were both substantial. We also consider it significant that this compensability matter was resolved short of hearing. Finally, we have found the expert observations offered by Mr. Kropp to have been instructive. The Referee's order is modified accordingly.

Penalty and related attorney fee pursuant to ORS 656.382(1)

We adopt the Referee's reasoning and analysis on this issue.

Remand

As we understand it, the purpose of claimant's alternative motion for remand pertains to the penalty issue. (Claimant's memorandum of law on waiver of attorney-client privilege, page 1, lines 17-19). Inasmuch as we have affirmed and adopted the Referee's decision on the penalty issue in all respects, it is unnecessary for us to address or discuss the various issues raised in claimant's cross-request for review. Moreover, we conclude such evidence would not be helpful to our inquiry concerning the amount of claimant's attorney fee in accordance with ORS 656.386(1). The request for remand is denied.

Attorney fee on review

Claimant is not entitled to an attorney fee award for services on review concerning the attorney fee issue or for his successful defense of the Referee's penalty assessment regarding the unreasonable claim processing issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 16, 1993 is modified in part and affirmed in part. In lieu of the Referee's attorney fee award of $15,496.25, claimant's counsel is awarded $9,500 as a reasonable attorney fee award pursuant to ORS 656.386(1) for services rendered in prompting the rescission of SAIF's denial prior to hearing, to be paid by SAIF. The remainder of the order is affirmed.

Board Member Hall dissenting.

After review of this case and the factors set forth in OAR 438-15-010(4), I find no basis to reduce the attorney fee as awarded by Referee T. L. Johnson, and therefore, dissent. The majority finds, and I agree, this case involved factually complex matters, a claim of substantial value to the claimant with significant benefits secured for claimant by claimant's skilled counsel. Indeed, these are the same conclusions reached by Referee T. L. Johnson. On this record, I see no basis to substitute our judgment of what constitutes a reasonable fee for that made by the Referee and would, therefore, affirm the attorney fee awarded by Referee T. L. Johnson.

March 30, 1994 Cite as 46 Van Natta 539 (1994)

In the Matter of the Compensation of
DENNIS HUTCHINSON, Claimant
WCB Case No. 92-12910
ORDER ON REVIEW
Dobbins, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Referee Baker's order that: (1) directed it to reclassify claimant's November 1990 injury claim as disabling; and (2) awarded a carrier-paid attorney fee for an alleged discovery violation. On review, the issues are claim processing and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation.

This is a claim for reclassification or aggravation of claimant's compensable November 1990 right ankle injury. There was no June 1991 injury.

Claimant perfected a claim for a worsened right ankle condition on February 2, 1992.

On or before December 3, 1991, claimant's compensable condition worsened, at least symptomatically. As a result of this worsening, claimant was less able to work than previously. This worsening is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Claim Processing

On August 28, 1991, the employer accepted claimant's claim for a November 1990 right ankle injury and classified the injury as nondisabling. (Ex. 9). On July 15, 1992, claimant's attorney informed

the employer that claimant had received no time loss payments, even though he was off work. (Ex. 23). On September 9, 1992, the employer received Dr. Puziss' September 1, 1992 report indicating that claimant had been disabled, due to his right ankle condition, since the first week in December 1991, when claimant quit working. (Ex. 25). With these documents, claimant objected to the nondisabling status of his claim.

The Referee directed the employer to reclassify claimant's November 1990 injury claim as disabling, finding that claimant requested reclassification less than a year after the claim was accepted. In reaching this result, the Referee relied on Robert E. Wolford, 45 Van Natta 435 (1993). However, since the Referee's order, we disavowed Wolford in Donald G. Stacy, 45 Van Natta 2360 (1993).[1] In any event, the one-year period for requesting reclassification of this nondisabling injury claim ran from the November 1990 date of claimant's injury.[2] See Donald R. Dodgin, 45 Van Natta 1642 (1993); Charles B. Tyler, 45 Van Natta 972 (1993); Gregory S. Meyers, 44 Van Natta 1759 (1992). Thus, the one-year period had expired when claimant requested reclassification in September 1992.

In addition, because this injury claim became disabling more than a year after the November 1990 date of injury, ORS 656.273 applies to the current claim for a worsened condition. See ORS 656.277(2); 656.273(4)(b); SM Motor Co. v. Mather, 117 Or App 176 (1992); Dianna L. Gordon, 46 Van Natta 271 (1994); Charles B. Tyler, supra. Therefore, to establish entitlement to compensation for a worsened right ankle condition the claim must be made as an aggravation claim under ORS 656.273.[3]

Under these circumstances, the first question is whether claimant perfected an aggravation claim under ORS 656.273(3). That statute provides: "A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation." We have held that to constitute an aggravation claim under the statute, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd on other grounds, Carlson v. Valley Mechanical, 115 Or App 371 (1992).

Claimant's request for reclassification is based primarily on Dr. Whang's February 1992 chart note, which the employer received on February 2, 1992. (See Ex. 13). In that report, Dr. Whang described claimant's November 1990 right ankle injury at work and noted that claimant performed light duty work following the injury, but his symptoms did not resolve. Dr. Whang stated:

> "During the first week of December 1991, the pain got worse and extended to the Achilles tendon and ankles. . . .[Claimant] was not able to perform his regular job and he had to quit work because of the pain. . . .On examination, the ankle joint is unstable and tender in the calcaneous. There is pain in the ankle and Achilles tendon. . . ." (Ex. 13).

In our view, Dr. Whang's report contains all the elements of a prima facie aggravation claim. Therefore, we find that claimant perfected an aggravation claim when the employer received this report.

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[1] In Stacy, we held that, for purposes of determining aggravation rights, the "date of injury" in occupational claims is either the date of disability or the date when medical treatment is first sought. 45 Van Natta at 2361; see Papen v. Willamina Lumber Company, 123 Or App 249 (1993).

[2] However, if an injury claim is accepted more than a year after the date of injury, the worker may still object to the initial claim classification by requesting a hearing, even though more than a year has passed since the injury. See Dodgin, supra. Inasmuch as claimant's nondisabling injury was not accepted more than one year after the date of injury, the Dodgin holding is not applicable. Moreover, because claimant was informed of claim acceptance approximately ten months after the injury, we conclude that claimant had sufficient time (two months) to challenge the initial classification within the statutory period (one year). See Charles B. Tyler, supra.

[3] Because this claim was properly initially classified as nondisabling, claimant's five year aggravation rights began running as of the November 1990 nondisabling injury. Thus, the February 2, 1992 aggravation claim was timely.

To establish a compensable worsening of his right ankle condition, claimant must show that increased symptoms or a worsened underlying condition rendered him less able to use his right ankle. Fred Meyer, Inc. v. Farrow, 122 Or App 164, 167 (1993) ("An aggravation of a scheduled injury is measured by increased loss of use.").

The employer argues that claimant failed to prove the claim, because there are no objective findings indicating that claimant's condition worsened. See ORS 656.273(1) and (3). We disagree.

Dr. Whang's February 1992 report describes claimant's history that his symptoms worsened in December 1991 such that claimant was no longer able to work. We have no reason to doubt claimant's history. The report further indicates that claimant continued to experience worsened right ankle symptoms at the time of Dr. Whang's examination. Such evidence meets the definition of "objective findings." See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). On this record, we conclude that claimant's compensable right ankle condition worsened on or before December 2, 1991, rendering claimant less able to work. As we have stated, claimant's worsened right ankle condition is established by medical evidence supported by objective findings. Consequently, the aggravation claim is proven.

Attorney Fees

The Referee assessed a $300 attorney fee, based on the employer's unreasonable delay in providing discovery. We affirm.

The employer argues that its conduct was not unreasonable, because the delay was inadvertent. We disagree.

The employer acknowledged claimant's initial request for discovery on January 22, 1992. (Ex. 10). On July 15, 1992, claimant's attorney informed the employer that he had not received any medical records "in quite some time." (Ex. 23). On September 28, 1992, claimant's attorney again requested that the employer provide documents related to the claim, including a concurrence letter and chart notes from Dr. Johansen. (Ex. 23).

On October 5, 1992, claimant requested a hearing. On October 8, 1992, the employer produced copies of Dr. Johansen's July 22, 1992 letter, which it had received on July 24, 1992 (see Ex. 21), and a February 6, 1992 CT scan. The employer's letter, which accompanied the documents, stated: "We thought these were previously provided to your office. We apologize for this oversight." (Ex. 27).

We have previously held that the excuse of oversight or inadvertence does not justify an otherwise unreasonable delay in the production of discoverable materials. See Michael R. Redden, 40 Van Natta 1851, 1853 (1988). Accordingly, considering the circumstances of this case, we agree with the Referee that the employer's delay of over two months was unreasonable and the attorney fee assessed on this basis was appropriate.

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 aggravation issue is $800, 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 services on review concerning the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated August 3, 1993 is modified in part and affirmed in part. In lieu of that portion of the order that directed the self-insured employer to process claimant's claim as disabling, the employer is directed to process the claim as an aggravation of the November 1990 compensable injury. The remainder of the order is affirmed.

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 92-06386
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The Board has received claimant's request for reconsideration of the Board March 3, 1994 Order on Reconsideration.

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 to the motion within 14 days from the date of this order. Thereafter, the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA T. GALICIA, Claimant
WCB Case No. 93-02625
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Daughtry's order which upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 29, 1993, claimant slipped on a wet floor when arriving at work. She lost her balance, but did not fall. The incident was unwitnessed.

The insurer raises the issue of claimant's credibility, contending that it is not possible to have an unwitnessed incident at the main entrance to the plant, such as claimant described, when 50 to 100 people walk through the entrance during the time of shift change. The insurer further contends that claimant is not credible because she denied any prior back injuries or pain to her physicians, whereas she sustained a compensable lumbar strain with a former employer in August 1990 which required treatment for approximately 10 months, and claimant did not return to work with that employer following the injury. (Ex. A-42).

The Referee believed that an incident occurred as claimant described. Nevertheless, the Referee concluded that claimant had failed to carry her burden of proving that her January 29, 1993 work incident was the major contributing cause of her disability and need for treatment pursuant to ORS 656.005(7)(a)(B). We are not persuaded, however, that ORS 656.005(7)(a)(B) applies in this case.

Although claimant has preexisting degenerative disc disease in her low back, there is no evidence that the preexisting condition combined with a compensable injury to cause or prolong disability or a need for treatment. Therefore, we do not analyze this claim under ORS 656.005(7)(a)(B). Accordingly, to establish compensability of her low back condition as an injury, claimant must establish that her slip at work is a material contributing cause of her disability and need for medical treatment. ORS 656.266; ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). We are not persuaded that claimant had met that burden of proof.

Claimant relies on the opinions of Dr. Cummings and Dr. Isaacson, orthopedic surgeon, to whom Dr. Cummings referred claimant. We generally give greater weight to the opinion of claimant's treating 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 rely on the opinion's of Drs. Cummings and Isaacson.

Dr. Cummings and Dr. Isaacson both relate claimant's disability and need for treatment to the work injury, based on the history claimant reported to the physicians. Dr. Isaacson stated in her report that claimant denied any previous back pain. (Ex. 8-1). Claimant reported to Dr. Cummings that she had never injured the area of her back for which she originally saw Dr. Cummings. (Ex. 9).

Prior to claimant's current work incident, however, she was off work due to an August 1, 1990 low back injury with another employer for over one year. (Ex. A-42). Claimant received treatment for severe low back pain after the August 1990 injury for at least a year. (Exs. A-26 to A-29). In August 1991, Dr. Poulson, orthopedic surgeon, recommended fusion surgery for the low back condition. (Ex. A-34).

Because the histories obtained from claimant by Dr. Cummings and Dr. Isaacson are unreliable, at best, we find that those physicians' opinions lack persuasive force. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). There is no other medical evidence which would support the requisite burden of proof for compensability. Accordingly, we are unable to conclude that claimant has carried her burden of proving that her January 29, 1993 alleged work incident is a material contributing cause of her current disability and need for treatment.

ORDER

The Referee's order dated June 15, 1993 is affirmed.

March 31, 1994 Cite as 46 Van Natta 543 (1994)

In the Matter of the Compensation of
WILLIAM J. HUMPHREYS, Claimant
WCB Case No. 92-15036
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Referee Peterson's order which: (1) upheld the insurer's denial of claimant's occupational disease claim for his bilateral knee condition; and (2) declined to assess a penalty for the insurer's allegedly untimely denial of the claim. On review, the issues are compensability and penalties.

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

Claimant has a preexisting rheumatoid arthritis condition, diagnosed in 1985, which affects his knees as well as other joints. In June 1992, claimant experienced significant swelling and pain in both knees. In July 1992, claimant filed a claim, alleging that work activities temporarily worsened his underlying arthritis condition.

Because claimant seeks to establish the compensability of an occupational disease claim, he must prove that work activities were the major contributing cause of the disease or its worsening. ORS 656.802(2). Because claimant has a preexisting rheumatoid arthritis condition in his knees, he must prove that work activities pathologically worsened the underlying disease, not merely increased his symptoms, in order to establish compensability. Weller v. Union Carbide, 288 Or 27 (1979); Aetna Casualty Co. v. Aschbacher, 107 Or App 494, 502-504 (1991). Claimant need not prove that the underlying condition permanently worsened to establish compensability; a temporary worsening is sufficient. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Michael J. Swirbul, 43 Van Natta 2413 (1991).

Only Dr. Valentine, claimant's treating rheumatologist, supports compensability of the claim. However, after our review of the record, we are unable to conclude that Dr. Valentine's opinion supports a finding that claimant sustained a pathological worsening of his underlying disease, even temporarily, rather than merely a temporary increase in symptoms, as a result of work activities in the Summer of 1992.

Dr. Valentine initially diagnosed an acute severe rheumatoid arthritis flare-up in June 1992. (Ex. 17-7). He explained that a "flare-up" refers to an increase in symptoms. (Ex. 34-26). Later, he changed the primary diagnosis to "synovitis" when he believed that work activities, rather than the rheumatoid arthritis, had become the dominant factor in claimant's knee symptoms. (Ex. 17-8; Ex. 34-28 to -29). However, he also noted that "synovitis" was not necessarily a change in diagnosis. He explained that "[s]ynovitis means inflammation in the knees [which] can be a manifestation of rheumatoid arthritis ." (Ex. 34-28). When claimant's knee condition resolved, Dr. Valentine opined that claimant's recent knee problems had been a "work-related exacerbation of his chronic rheumatoid synovitis." (Ex. 23-1).

We find no more specific discussion in Dr. Valentine's reports or his deposition testimony regarding the question of whether claimant's work activities pathologically worsened his preexisting rheumatoid arthritis condition. On the other hand, Dr. Fraback, the examining rheumatologist, opined that claimant's work activities were not the major contributing cause of a worsening of his rheumatoid arthritis. (Ex. 33-2). Under these circumstances, we conclude that claimant failed to prove that work activities pathologically worsened his preexisting rheumatoid arthritis disease.

Accordingly, we adopt and affirm the Referee's analysis, as supplemented herein, upholding the insurer's denial of claimant's occupational disease claim. Because we have found the occupational disease claim not compensable, we also adopt and affirm that portion of the Referee's order which declined to assess a penalty for the insurer's untimely denial of the claim.

ORDER

The Referee's order dated May 5, 1993 is affirmed.

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Cite as 318 Or 363 (1994) February 25, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of William F. Gilmore, Claimant.

NORPAC FOODS, INC., Petitioner on Review
v.
WILLIAM F. **GILMORE**, Respondent on Review
(WCB 91-04989, 91-04663; CA A78880; SC S40614)

On review from the Court of Appeals.*
Argued and submitted January 6, 1994.
Chess Trethewy, of Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem, argued the cause and filed the petition for petitioner on review.
David W. Hittle, of Burt, Swanson, Lathen, Alexander & McCann, Salem, argued the cause for respondent on review.
Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Unis, and Graber, Justices.
UNIS, J.
The decision of the Court of Appeals and the order of the Workers' Compensation Board are reversed. This case is remanded to the Workers' Compensation Board for further proceedings.
* Judicial review of order of Workers' Compensation Board. 123 Or App 122, 858 P2d 183 (1993).

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318 Or 365> The issue in this workers' compensation case is whether claimant's injury is compensable solely because it occurred in a parking lot owned and maintained by employer.

On March 4, 1991, claimant worked a full shift as a quality control grader at employer's place of business. At the end of his shift, claimant left the plant and walked to his car, which was parked in a lot owned and maintained by employer. When claimant got to his car, he opened the door and began to enter the vehicle. As claimant was sliding into the driver's seat of his car, he felt his right knee "grab/lock up," which produced excruciating pain. He backed out of the car and kicked his right leg out straight, which produced a popping sound, along with swelling and extreme pain in his right knee. Claimant drove home. At the time claimant was injured, he had completed all work duties, and he was not compensated by employer for the time between completion of his duties and his arrival home.

The next day, claimant went to the emergency room of a local hospital for the pain in his right knee. The attending physician took claimant off work and advised claimant to visit an orthopedic surgeon. Claimant subsequently received treatment, including arthroscopy, from an orthopedic surgeon for the damage to his right knee. The treatment was successful, and claimant returned to work in April 1991.

On April 17, 1991, claimant filed a workers' compensation claim, contending that he had injured his knee as a result of his work on March 4, 1991. Employer denied that claim on April 22, 1991. A hearing was held before a Workers' Compensation Board (Board) hearings referee. The referee affirmed employer's denial of the claim because claimant did not establish a causal link between a condition associated with employer's parking lot and claimant's injury. On review, the Board reversed the referee's decision, relying on *Boyd v. SAIF*, 115 Or App 241, 244, 837 P2d 556 (1992), in which the Court of Appeals held that "[t]he fact that an injury occurs on employer-controlled premises while the employee is travelling to and from work makes the incident sufficiently work connected" to make the injury compensable.

318 Or 366> Employer petitioned for judicial review of the Board's order, and the Court of Appeals affirmed without opinion. *Norpac Foods, Inc. v. Gilmore*, 123 Or App 122, 858 P2d 183 (1993). This court allowed employer's petition for review to consider the compensability of injuries sustained in an employer-controlled parking lot. For the reasons that follow, we reverse the decision of the Court of Appeals and the order of the Board. We remand this case to the Board for further proceedings.

For an injury to be compensable under workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). Some courts have interpreted that phrase as creating

two distinct tests, each of which must be satisfied for an injury to be compensable. This court has adopted a unitary approach, in which "arising out of" and "in the course of" are two elements of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980). Each element of the inquiry tests the work-connection of the injury in a different manner. The requirement that the injury occur "in the course of employment" concerns the time, place, and circumstances of the injury. *Clark v. U.S. Plywood*, 288 Or 255, 260, 605 P2d 265 (1980). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. *Id.* In assessing the compensability of an injury, we must evaluate the work-connection of both elements; neither is dispositive.

We first examine whether claimant's injury arose "in the course of" employment. This court follows the well-established "going and coming" rule, under which injuries sustained while an employee is going to and coming from the employee's regular place of employment generally are not considered to have occurred in the course of employment. *Philpott v. State Ind. Acc. Com.*, 234 Or 37, 40, 379 P2d 1010 (1963). The "going and coming" rule is not, however, an absolute bar to compensability. *See id.* at 41 (listing generally recognized exceptions).

One exception to the "going and coming" rule is the so-called "parking lot rule." Under the "parking lot rule," **<318 Or 366/367>** injuries sustained on the employer's premises while the employee is proceeding to or from work have a sufficient work-connection to be considered to have occurred "in the course of employment." *Cope v. West American Ins. Co.*, 309 Or 232, 785 P2d 1050 (1990); *Kowcun v. Bybee*, 182 Or 271, 186 P2d 790 (1947).

In this case, the Board and the Court of Appeals have taken the approach that if an injury occurs in an employer-controlled parking lot, it is *per se* compensable. In reaching that conclusion, the Board and the Court of Appeals have relied on this court's decision in *Cope v. West American Ins. Co., supra.* Both the Board and the Court of Appeals have misread the decision in *Cope.*

In *Cope v. West American Ins. Co., supra,* the plaintiff was injured while walking to work when she was struck by a vehicle driven by a co-worker. The injury occurred near the edge of an employer-controlled parking lot, in which the plaintiff had parked her car. The plaintiff's insurance company denied her underinsured motorist claim.[1] The plaintiff filed an action seeking a declaratory judgment that she was entitled to coverage. The defendants sought summary judgment, arguing that the plaintiff's exclusive remedy was through the workers' compensation system because the injury "arose out of and in the course of employment." The trial court granted summary judgment for defendants. This court reversed, holding that summary judgment was inappropriate because a genuine issue of material fact existed as to whether the injury occurred in the employer's parking lot or on a public sidewalk. In the process, this court discussed the "parking lot rule":

> "[W]hen an employee travelling to or from work sustains an injury on or near the employer's premises, there is a 'sufficient work relationship' between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained. Whether the requisite control is evinced by increased, employer-created risks, or by the employer's property rights to the area where the injury is **<318 Or 367/368>** sustained, is immaterial. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable." *Cope v. West American Ins. Co., supra,* 309 Or at 239 (citations omitted).

That passage may seem to imply that an injury that occurs in an employer-controlled parking lot is *per se* compensable. Reading that passage in context, however, leads to a different conclusion. First, *Cope* was decided on the basis of whether summary judgment was appropriate. This court's holding in that case was that a genuine issue of material fact existed as to where the injury occurred, specifically whether the

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[1] The plaintiff's claim for workers' compensation had been denied. The plaintiff then filed a claim under the co-worker's liability insurance and received $25,000, the limit of that policy. The plaintiff subsequently filed the underinsured motorist claim with her own insurer that was at issue in *Cope v. West American Ins. Co.*, 309 Or 232, 785 P2d 1050 (1990).

injury occurred in the employer-controlled parking lot or on a public sidewalk. This court was not called on to apply the "parking lot rule" to determine compensability of the plaintiff's injury. Thus, the quoted passage is dictum. Second, the quoted passage dealt only with the question of when the "parking lot rule" applies, *i.e.*, how much employer control is necessary for the "parking lot rule" to become operative. *Cope* did not address the question of how the "parking lot rule" operates in determining compensability. Such an inquiry was unnecessary in that case. This court's decision in *Cope* should not, therefore, be read as establishing a rule that, irrespective of other principles of workers' compensation law, injuries sustained in an employer-controlled parking lot are per se compensable.

The "parking lot rule" establishes only that the time, place, and circumstances of the injury are sufficiently work-related to justify compensability. As noted above, however, the time, place, and circumstances of the injury are only a portion of the inquiry into work-connection.

A claimant must also establish a causal connection between the injury and the employment, which is the second element of our unitary work-connection inquiry, namely, whether the injury "arose out of" the employment. It is well-established that an "employer * * * is not liable for any and all injuries to its employe[es] irrespective of their cause, and the fact that an employe[e] is injured on the premises during working hours does not of itself establish a compensable injury. The employe[e] must show a causal link between the occurrence of the injury and a risk connected with his or her **<318 Or 368/369>** employment." *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29, 672 P2d 337 (1983).

In this case, claimant was injured while getting into his car in an employer-owned parking lot immediately after the end of his shift. Thus, claimant's injury falls squarely within the "parking lot rule" and, therefore, occurred "in the course of" his employment. As we have stated, however, the mere fact that an injury occurs in a parking lot that is owned and maintained by an employer when an employee is going to and coming from the employee's regular place of employment does not, in and of itself, establish compensability. Claimant's injury must also "arise out of" the employment, *i.e.*, some causal connection must be demonstrated.

In reversing the decision of the hearings referee, the Board erred in determining that claimant's injury was compensable solely on the basis of where the injury occurred. Instead, the Board should have examined the causal connection between claimant's employment and the injury to determine if, in considering all the circumstances, claimant had shown a sufficient work-connection to justify compensability. The record being complete, it would be permissible for this court to address the question whether there is evidence to permit such a finding. However, because the Board is the last fact-finding level in the workers' compensation review process, we believe that it is appropriate to remand this case to the Board to apply, in the first instance, the facts that it finds to the law that we announce here.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are reversed. This case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 318 Or 370 (1994) February 25, 1994

IN THE SUPREME COURT OF THE STATE OF OREGON

SISTERS OF ST. JOSEPH OF PEACE, HEALTH, AND HOSPITAL SERVICES, a Washington corporation, dba SACRED HEART GENERAL HOSPITAL, Petitioner on Review,

v.

NATHAN G. **RUSSELL**, Defendant, and THE AETNA CASUALTY AND SURETY COMPANY, Respondent on Review.

(CC 16-90-04757; CA A74348; SC S40584)

On review from the Court of Appeals.*

Argued and submitted January 5, 1994.

James R. Strickland, of Curtis & Strickland, Eugene, argued the cause and filed the petition for petitioner on review.

Darren L. Otto, of Scheminske & Lyons, Portland, argued the cause for respondent on review and filed a response to the petition.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Unis, and Graber, Justices.

GRABER, J.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is affirmed.

*Appeal from Lane County Circuit Court, Pierre L. Van Rysselberghe, Judge. 122 Or App 188, 857 P2d 192 (1993).

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318 Or 372> This case involves principles relating to third-party beneficiary contracts.

FACTS AND PROCEDURAL BACKGROUND

On September 13, 1984, Russell was injured when the log scaler that he was operating rolled down a hill. As a result of that accident, Russell's back and arm were broken. Sacred Heart General Hospital (hospital) provided medical treatment for his injuries from September 13, 1984, through August 30, 1985.

Russell was uncertain who his employer was at the time of the injury. For that reason, he filed four separate workers' compensation claims against four purported employers. After a hearing concerning all four claims, a referee held that an employer insured by The Aetna Casualty & Surety Company (Aetna) was Russell's employer for workers' compensation purposes. The Workers' Compensation Board (Board) affirmed. Aetna and Russell sought judicial review in the Court of Appeals.

While those petitions for judicial review were pending, the four purported employers and their insurers, including Aetna, entered into a Disputed Claim Settlement (DCS) agreement with Russell. The Board approved the DCS agreement pursuant to ORS 656.289(4),[1] and Aetna and Russell dismissed their petitions for judicial review of the Board's order.

Plaintiff hospital then brought this action against Russell and Aetna to recover for the medical care that plaintiff had provided to Russell. Plaintiff pleaded two theories of recovery against Russell: contract implied in fact (Claim 1) and account stated (Claim 2). Plaintiff also pleaded a claim against Aetna (Claim 3). That claim was based on the theory that plaintiff was a third-party beneficiary of the DCS agreement, to which Russell and Aetna were parties. The case was tried to a jury.

318 Or 373> At trial, plaintiff called Russell as a witness. Russell testified that he never agreed to "personally pay" plaintiff's bills, although he did not refuse the hospital's treatment and agreed that the treatment saved his life. Plaintiff's only other witness was its director of patient accounts, who testified as to the charges billed and gave the opinion that the charges were reasonable. Plaintiff also introduced the DCS agreement and the hospital bills into evidence.

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[1] ORS 656.289(4) provides in part that, "in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of * * * the board * * *, by agreement make such disposition of the claim as is considered reasonable."

At the close of all the evidence, Aetna moved for a directed verdict, pursuant to ORCP 60,[2] on Claim 3. Aetna argued two separate points: (a) that "there is no evidence of a third-party beneficiary contract," and (b) that "Plaintiff has * * * not presented any expert testimony sufficient to show that the [hospital] services that were allegedly provided to Defendant Russell were services which were reasonable * * * and necessary" to treat Russell's injuries. The trial court denied Aetna's motion. Thereafter, the jury returned a verdict for Russell on Claims 1 and 2 and for plaintiff against Aetna on Claim 3, the claim based on the DCS agreement.[3]

The trial court entered judgment on the verdict. Aetna appealed, assigning as error the denial of its motion for a directed verdict on Claim 3.[4]

The Court of Appeals reversed. *Sisters of St. Joseph v. Russell*, 122 Or App 188, 857 P2d 192 (1993). That court rejected plaintiff's characterization of Claim 3 as one based entirely on its rights as a third-party beneficiary of an express contract, the DCS agreement. 122 Or App at 191. The court concluded that, instead, plaintiff's express contract claim against Aetna "incorporates an implied agreement between plaintiff and Russell," so that plaintiff's right to recover depended on Russell's actual liability to plaintiff; plaintiff, therefore, could not recover unless it proved all the elements **<318 Or 373/374>** of Claim 1, its implied contract claim against Russell. *Id.* at 191-92. The court then held that, because "there was no admissible evidence that what was supplied was necessary for the care of Russell," the trial court erred in not granting Aetna's motion for directed verdict. *Id.* at 192. One judge concurred, stating that "[p]laintiff was, at best, an incidental beneficiary of the [DCS] agreement and not entitled to bring an action as a third-party beneficiary of Russell's contract." *Ibid.* (Warren, P.J., concurring). One judge dissented, on the ground that the DCS agreement was ambiguous, that the jury was entitled to decide whether plaintiff was an intended third-party beneficiary of the DCS agreement, and that, "because the jury decided this case on the basis of an express contract, testimony concerning the reasonableness or necessity of the [medical] services [provided to Russell by plaintiff] is irrelevant." *Id.* at 193-95 (Landau, J., dissenting). We allowed plaintiff's petition for review and now reverse the decision of the Court of Appeals.

PLAINTIFF AS THIRD-PARTY BENEFICIARY

Plaintiff's claim against Aetna was based on a single theory: "[t]hat Sacred Heart General Hospital became a third-party beneficiary of" the DCS agreement between Aetna and Russell, "pursuant to said agreement." We begin by examining that assertion. In the procedural posture of this case, we apply the following standard of review:

> "We * * * come to the issue of whether the trial court erred in denying defendant's motion for a directed verdict. Because plaintiff had the verdict, we cannot set it aside unless we can affirmatively say that there is no evidence from which the jury could have found the facts necessary to establish the elements of plaintiff's cause of action. Or Const Art VII (Amend), 3. We do not weigh the evidence; we consider the evidence, including inferences, in the light most favorable to plaintiff."

Brown v. J.C. Penney Co., 297 Or 695, 705, 688 P2d 811 (1984).

As a general proposition, a third party's right to enforce a contractual promise in its favor depends on the intention of the parties to the contract. Oregon case law recognizes three categories of

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[2] ORCP 60 provides, in part, that "[a]ny party may move for a directed verdict at the close of the evidence offered by an opponent or at the close of all the evidence."

[3] With respect to Claim 3, the jury verdict stated:

"$96,888.74."

[4] Plaintiff did not appeal concerning Claims 1 and 2, which were its claims against Russell. As a result, Claims 1 and 2 were not at issue on appeal and are not at issue on review.

third-party beneficiaries: donee **<318 Or 374/375>** beneficiaries, creditor beneficiaries, and incidental beneficiaries. *See Johnston v. The Oregon Bank*, 285 Or 423, 429-30, 591 P2d 746 (1979) (considering whether the plaintiff was a donee, creditor, or incidental beneficiary). For a plaintiff to be a donee beneficiary, "it must appear that the [promisee's] intent in obtaining [the promisor's] promise to [perform] was to make a gift to [the] plaintiff or to confer a right to [performance] upon [the] plaintiff, which [performance] was not due *or claimed to be due* by the [promisee] to [the] plaintiff." *Northwest Airlines v. Crosetti Bros.*, 258 Or 340, 346, 483 P2d 70 (1971) (emphasis added). For a plaintiff to be a creditor beneficiary, "the performance * * * by [the promisor] must be to 'satisfy an actual *or supposed or asserted duty* of the promisee * * * to the [plaintiff].'" *Ibid.* (emphasis added; citation omitted). Finally, if the third party has paid no value and there is no intention to confer a contract right on that party, then the party is an incidental beneficiary who is not entitled to an action on the contract. In those circumstances, "the contract will not be interpreted to promise performance to the third-party stranger to the contract even though the stranger may incidentally benefit from the contract." *Aetna Casualty & Surety Co. v. OHSU*, 310 Or 61, 65, 793 P2d 320 (1990). In short, the first two categories of beneficiaries are entitled to enforce directly contractual promises intended to be for their benefit, even though they are strangers to the contract. Incidental beneficiaries are not so entitled.

In this case, plaintiff gave medical care to Russell. Plaintiff billed Russell for that medical care. In other words, at the time the DCS agreement was signed, plaintiff had given something of value to Russell and was asserting that Russell had a duty to pay for it. In those circumstances, plaintiff was a creditor beneficiary of the DCS agreement *if* the parties intended that contract to benefit plaintiff. To determine whether Aetna and Russell intended to benefit the hospital, we must examine the DCS agreement.

In numbered paragraph 1 of the DCS agreement, Russell "allege[d] that he ha[d] incurred" certain "medical expenses" as a result of the injury that gave rise to the settlement, including "Sacred Heart Hospital, Eugene, OR [$]98,872.50." Paragraph 2 provided:

> **318 Or 376>** "That Aetna Casualty & Surety Co. will hold * * * Russell harmless in regard to the above alleged medical expenses, including, but not limited to all principal, interest, penalties, attorneys' fees or any other charges or claims or demands or causes of action or suit against him by reason of the above alleged medical bills and/or obligations. [Russell] agrees that as between Aetna and the medical providers, Aetna is free to make whatever arrangements they wish with regard to settlement of the alleged bills."

Paragraph 3 of the DCS agreement specified that Russell could keep the time loss payments that he had received from Aetna. Paragraph 4 awarded a lump sum settlement to Russell and his lawyers. Paragraph 5 absolved the four purported employers and their insurers of any further responsibility for Russell's

> "disputed and denied conditions excepting, however, the terms [that] this agreement provide[,] and the parties agree that the sums heretofore set forth to be the sole responsibility of the carrier Aetna Casualty & Surety Company."

Paragraph 6 of the DCS agreement included various general provisions relating to the settlement and stated that, after the date of the DCS agreement, Russell would be responsible "for his own temporary and permanent disability due to this injury and/or medical care and * * * for future medical expenses incurred due to these conditions and also including [Russell's] sole responsibility for any aggravation or permanent disability attendant thereto." Paragraph 6 also provided:

> "[Russell] and his attorney agree and warrant that the above named health care providers are the only health care providers which have provided services to [Russell] in relation to this claim and Aetna Casualty & Surety Company shall be solely responsible for resolving the claims of said creditors and as hereinabove set forth shall indemnify and hold [Russell] harmless therefrom including any and all claims, demands, causes of action or suit, attorney fees, penalties, interest or otherwise arising out of the aforesaid bills by medical providers but that [Russell] shall be solely responsible for any future obligations or bills incurred for treatment of his condition."

The trial court held that the DCS agreement was ambiguous and, accordingly, that the issue should be decided by the jury. This court has explained:

> **318 Or 377>** "Unambiguous contracts must be enforced according to their terms. Whether the terms of a contract are ambiguous in the first instance is a question of law. If a contract is ambiguous, the trier of fact will ascertain the intent of the parties and construe the contract consistent with the intent of the parties."

OSEA v. Rainier School Dist. No. 13, 311 Or 188, 194, 808 P2d 83 (1991) (citations omitted).

We conclude that the trial court did not err in denying Aetna's motion for a directed verdict on the asserted ground that "there is no evidence of a third-party beneficiary contract." In so concluding, we note that plaintiff did not move for a directed verdict in its favor on that question and that neither party asserts in this court that the jury received erroneous instructions or an erroneous verdict form with respect to that question. Our holding, therefore, is limited in scope.

The most natural reading of paragraph 2 is that Aetna *must pay the listed medical providers*, although it remains free to negotiate concerning the *amount* to be paid to a given provider and the payment arrangements, such as timing.

Aetna argues, however, that the DCS agreement also could be read to suggest that the parties intended to settle Russell's workers' compensation claim without concern for the ability of plaintiff or other third-party health care providers to receive payment.

Other provisions demonstrate an intention to require Aetna to pay the third parties listed in paragraph 1 of the DCS agreement. For example, in paragraph 5 "the parties agree that *the sums heretofore set forth to be the sole responsibility of the carrier Aetna Casualty & Surety Company.*" (Emphasis added.) The phrase "the sums heretofore set forth" may be read to include the medical expenses listed in paragraph 1. Further, in paragraph 6, Russell "warrant[s] that the above named health care providers are the only health care providers which have provided services to [Russell] in relation to this claim and Aetna Casualty & Surety Company shall be solely responsible for resolving the claims of said creditors." Also in paragraph 6, Russell agrees **<318 Or 377/378>** to "be fully responsible for future medical expenses incurred." As a whole, paragraph 6 may be read to demonstrate that the parties *intended for all health care providers to be paid*, but simply divided the responsibility for payment between past and future expenses.

In deciding whether the parties to the DCS agreement intended to benefit plaintiff, the jury could consider, not only the terms of the contract, but also the circumstances under which the contract was made. *See* ORS 42.220 ("In construing an instrument, the circumstances under which it was made, including the situation of the subject and of the parties, may be shown so that the judge is placed in the position of those whose language the judge is interpreting."); *McDonald v. Supple*, 96 Or 486, 495-96, 190 P 315 (1920) (applying predecessor statute in context of jury trial and holding that evidence was admissible to show the meaning of ambiguous term of agreement). One of the circumstances was the potential liability facing Aetna and Russell at the time that they signed the DCS agreement.

Had Russell prevailed in his workers' compensation claim against Aetna's insured, Aetna would have been legally responsible for paying all of Russell's past and future medical bills attributable to his compensable injury, including the hospital bills at issue here. *See* ORS 656.245 (requiring insurer to provide medical services, including surgical, hospital, and nursing services, and medications and similar supplies, for every compensable injury). Had Russell's accident been held noncompensable, as Aetna was contending in the petition for judicial review that was pending at the time the DCS agreement was signed, Russell could have been legally responsible for paying all of his own medical expenses, including those owed to plaintiff. In the light of those circumstances, a possible interpretation of the DCS agreement was that all of the health care providers *must and would be paid* by someone and that the only question was who would be responsible to pay which bills -- a question settled by Aetna's promise to pay past bills and Russell's promise to be responsible for future bills.

The jury also could infer from the extent of Russell's injuries, the extent of medical treatments provided, and the substantial size of the hospital bills that the parties to the **<318 Or 378/379>** DCS agreement intended to ensure that someone would pay plaintiff. Finally, from Russell's testimony that plaintiff's services saved his life, the jury could infer that Russell, at least, intended that plaintiff be paid by Aetna.

In summary, the trial court did not err in denying Aetna's motion for a directed verdict on the asserted ground that, as a matter of law, plaintiff was not an intended third-party beneficiary of the DCS agreement.

PROOF OF ENTITLEMENT TO RECOVERY

We turn to the question whether, in order to enforce the DCS agreement in its favor, plaintiff was required to prove that the medical services that it provided to Russell were necessary. Because of the procedural posture of the case, the same standard of review applies to this question as applied to the question whether plaintiff was an intended third-party beneficiary of the contract. Again, plaintiff did not seek a directed verdict in its favor and, again, there is no challenge to the adequacy of the jury instructions or the verdict form as to this question.

In general, a third-party creditor beneficiary's right to recover against the promisor is subject to any claim or defense arising from the beneficiary's own conduct or agreement. *See* Restatement (Second) of Contracts, 309(4) and comment *c* (1981) (so stating; "The conduct of the beneficiary * * * may give rise to claims and defenses which may be asserted against him by the obligor, and his right may be affected by the terms of an agreement made by him."). In this case, Aetna asserts that plaintiff provided medical services to Russell that were not proved to be necessary.

Assuming that Aetna's factual assertion is accurate,[5] plaintiff's claim is not barred by that defense. That is because the contract that a third-party beneficiary seeks to enforce **<318 Or 379/380>** may provide that some or all otherwise-available defenses do not apply.

Aetna argues that paragraph 2 of the DCS agreement can be read to suggest that the parties intended to condition the intention to benefit plaintiff on plaintiff's negotiations with Aetna regarding the hospital bills; the absence of proof that the hospital services were "necessary for the care of Russell" could be a basis for such negotiations.

Paragraph 5 of the DCS agreement, however, makes "*the sums* heretofore set forth" "the sole responsibility of the carrier Aetna." (Emphasis added.) One of those *sums* is stated to be *the full and exact dollar amount of plaintiff's bills* for Russell's care. In addition, as discussed above, paragraph 6 may be read to suggest that the DCS agreement simply divided responsibility for payment of medical expenses, as between Russell and Aetna, based *only* on whether the expenses were for past or future care. Paragraph 6 refers to the medical providers, including plaintiff, as Russell's "creditors." As a whole, the paragraph suggests that the parties to the DCS agreement recognized that Russell's medical expenses, as listed in paragraph 1, were, in fact, owed.

The trial court did not err in denying Aetna's motion for a directed verdict on the asserted ground that plaintiff failed to prove a required element of its claim.

CONCLUSION

In summary, the trial court did not err in denying Aetna's motion for a directed verdict on either of the grounds asserted by Aetna. There are no other issues before us concerning the propriety of the jury's verdict, and that verdict must be sustained.[6]

The decision of the Court of Appeals is reversed. The judgment of the circuit court is affirmed.

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[5] The parties agree that the following statement by the Court of Appeals, concerning the record in this case, is correct:

> "Plaintiff presented evidence that it provided to Russell the medical services for which it sought payment. Moreover, it presented evidence that the charges for the medical services were reasonable. However, there was no admissible evidence that what was supplied was necessary for the care of Russell."

Sisters of St. Joseph v. Russell, 122 Or App 188, 192, 857 P2d 192 (1993).

[6] We also have considered Aetna's remaining assignment of error on appeal and conclude that it is not well taken.

Cite as 123 Or App 383 (1993) September 29, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Steven Harsh, Claimant.

STEVEN C. **HARSH**, Petitioner,
v.
HARSCO CORPORATION and CIGNA INSURANCE COMPANY, Respondents.
(WCB 90-21949; CA A75203)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 14, 1993.
Merrill Schneider, Portland, argued the cause for petitioner. With him on the brief were Daniel J. DeNorch and Schneider & DeNorch, Portland.
Craig A. 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 Edmonds and Landau, Judges.
WARREN, P.J.
Affirmed.

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123 Or App 385> Claimant seeks review of an order of the Workers' Compensation Board that upheld an order of the Director of the Department of Insurance and Finance, which denied claimant's request for vocational assistance. We affirm.

Claimant suffered a compensable injury in 1979. After his aggravation rights had expired, he sought vocational assistance, which was denied. Claimant requested administrative review of the denial by the director, pursuant to ORS 656.283(2). The director concluded that claimant was not eligible for vocational assistance, because claimant did not have a substantial handicap to employment. Claimant requested a hearing, and the referee held that claimant was not entitled to vocational assistance, because his claim was in own motion status and ORS 656.278 does not authorize vocational services. The Board affirmed the denial of vocational services. It rejected the referee's basis for decision, explaining that that issue was not properly before it, because the director did not base his conclusion on that ground. Instead, it reviewed the director's order pursuant to ORS 656.283(2), and concluded that none of the reasons specified by statute for modification of the director's order existed. Therefore, it affirmed.

Claimant argues first that the Board's order is not sufficient for judicial review. We reject that argument without discussion. He also argues that the Board was wrong in upholding the director's order, because that order violated ORS 656.340, which sets out the eligibility criteria for vocational assistance. Employer responds that the Board's order should be affirmed, because a claimant whose claim is in own motion status cannot be eligible for vocational assistance.

The preliminary question is how we review the Board's order that, in turn, reviews a director's order under ORS 656.283. The Board may modify the decision of the director only if it:

> "(a) Violates a statute or rule;
>
> "(b) Exceeds the statutory authority of the agency;
>
> "(c) Was made upon unlawful procedure; or
>
> **123 Or App 386>** "(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion." ORS 656.283(2).

We review the Board's order for errors of law and substantial evidence. ORS 656.298; *Colclasure v. Wash. County School Dist. No. 48-J*, 117 Or App 128, 843 P2d 953 (1992), *rev'd on other grounds* 317 Or 526, ___ P2d ___ (1993); *Lasley v. Ontario Rendering*, 114 Or App 543, 836 P2d 184 (1992).

Employer argues that, under ORS 656.278(1), when a claimant's aggravation rights have expired, the claimant may obtain additional benefits only pursuant to the Board's own motion authority. That authority, according to employer, is limited to directing payment of certain medical benefits and temporary disability compensation. There is no authority for granting vocational assistance to a claimant in own motion status. We agree with employer that, if a claimant who is in own motion status is not eligible for vocational assistance under ORS 656.278, then the director's order denying that assistance, and the Board's order upholding that denial, should be affirmed. Therefore, the first question is whether a claimant seeking benefits under ORS 656.278 is eligible for vocational services.

ORS 656.278 provides, in part:

> "(1)Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:
>
> "(a)There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

In *Independent Paper Stock v. Wincer*, 100 Or App 625, 788 P2d 466, rev den 310 Or 195 (1990), we explained that, before the 1987 amendments to ORS 656.278, that statute contained broad language that authorized the Board, on its own motion, to modify, change or terminate benefits if it concluded that such action was justified. In 1987, however, **<123 Or App 386/387>** the legislature added "limiting language abolishing the Board's authority to award permanent disability benefits on own motion claims." 100 Or App at 628. (Footnote omitted.) We adhered to that view in *State ex rel Borisoff v. Workers' Comp. Board*, 104 Or App 603, 802 P2d 98 (1990). The premise of those decisions is that the workers' compensation system is purely a creature of statute, *see Wright v. Bekins Moving & Storage Co.*, 97 Or App 45, 49, 775 P2d 857, *rev den* 308 Or 466 (1989), and that a claimant is entitled only to those benefits that are authorized by statute.

The inevitable extension of that premise and those cases is that the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1). For a claimant whose injury occurred on or after January 1, 1966, the statute provides only for the payment of certain medical benefits and temporary disability compensation for the time allowed by statute. ORS 656.278(1)(a). There is no statutory authority for an award of any other additional benefits, including vocational services. It follows that the director's order denying claimant vocational assistance was correct, although for a reason different from that stated in his order.

Affirmed.

Cite as 123 Or App 418 (1993) September 29, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Curtis W. Stinson, Claimant.

HAMMON STAGE LINE and EMPLOYERS INSURANCE OF WAUSAU, a Mutual Company, Petitioners - Cross-Respondents,

v.

CURTIS W. **STINSON**, Respondent - Cross-Petitioner.

(89-16397; CA A75509)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 9, 1993.

David O. Horne, Beaverton, argued the cause for petitioners - cross-respondents. With him on the brief was Wausau Insurance Companies, Beaverton.

Arthur Klosterman, Salem, argued the cause for respondent - cross-petitioner. With him on the brief was Whitehead & Klosterman, Salem.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

LANDAU, J.

Reversed on petition and remanded for reconsideration; affirmed on cross-petition.

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123 Or App 420> Employer petitions for review of an order of the Workers' Compensation Board that held that the doctrine of claim preclusion bars claimant from challenging the wage rate used to calculate his temporary total disability benefits, but not his permanent total disability benefits. Claimant cross-petitions for review of the same order.

Claimant was injured in an automobile accident on December 17, 1982. Employer accepted his workers' compensation claim. Although claimant had regularly worked overtime before the accident, employer calculated his temporary total disability compensation at a rate that did not take overtime into account. On November 4, 1984, a determination order issued closing the claim and awarding claimant temporary total disability and 30 percent unscheduled permanent partial disability. No one requested a hearing.

The claim later was reopened for vocational assistance. On July 29, 1988, a determination order issued closing the claim again and awarding claimant additional temporary total disability, but only 20 percent unscheduled permanent partial disability. Claimant requested a hearing. On April 12, 1989, the referee awarded claimant permanent total disability. Employer then requested review by the Workers' Compensation Board.

On August 15, 1989, while review of the referee's order was pending, claimant requested a hearing on employer's failure to pay the permanent total disability awarded by the referee. In amended requests for hearing, filed on September 18, 1989, and on November 27, 1989, claimant asked for review of the wage rates used to calculate the temporary total disability benefits awarded in both the 1984 and the 1988 determination orders. He also asked for review of the wage rates used to calculate his permanent total disability benefits awarded in the 1989 referee's order. Claimant asserted, for the first time, that employer had improperly failed to include regularly-worked overtime in its calculations of his wage rate.

On August 10, 1990, the Board affirmed the 1989 referee's order, which had awarded permanent total disability. No one sought judicial review.

123 Or App 421> On September 4, 1991, the referee issued an order on the challenge to the wage rates used to calculate claimant's temporary total disability and permanent total disability benefits. The referee ordered employer to recalculate the payments using the correct wage rate and to pay claimant the additional amount due. Employer requested Board review.

The Board modified the referee's order. Relying on *Drews v. EBI Companies*, 310 Or 134, 795 P2d 531 (1990), it held that the doctrine of claim preclusion bars claimant from challenging his wage rate with respect to his temporary total disability payments, but not his permanent total disability payments.

In its petition for review, employer first argues that the Board erred in ordering any change in permanent total disability benefit payments to include overtime wages. There is no rule, employer argues, requiring the inclusion of overtime wages. That issue, however, was neither raised nor argued before the Board, and we will not entertain it for the first time on judicial review. *EBI Ins. Co. v. Chandler*, 112 Or App 275, 277, 828 P2d 1047 (1992); *Northwest Advancement v. Wage and Hour Comm.*, 96 Or App 146, 148, 772 P2d 934, *rev den* 308 Or 315 (1989), *cert den* 496 US 907 (1990).

Employer next argues that the Board should have concluded that the doctrine of claim preclusion bars claimant from challenging his wage rate with respect to both temporary and permanent disability benefits. In his cross-petition, claimant argues that the Board should have concluded that claim preclusion does not bar him from challenging the wage rate with respect to either temporary or permanent disability benefits. Neither party is correct.

The Supreme Court's decision in *Drews* is dispositive. In *Drews*, the claimant was injured at a time when he was earning $10.50 per hour. His employer, however, incorrectly calculated his wage at $8.50 per hour and paid temporary disability benefits on the basis of that rate. A 1981 determination order awarded temporary total disability benefits for a specified time period. No one requested a hearing. Temporary total disability benefits continued to be paid on the basis of the incorrect wage rate. In 1984, the claimant filed an aggravation claim. The employer denied the claim, **<123 Or App 421/422>** but the referee ordered the payment of temporary total disability payments. The following year, a determination order issued allowing temporary total disability benefits for a limited period. The claimant requested a hearing, and at that time first challenged the wage rate used to calculate his temporary disability benefits. The Board held that, because the wage rate challenge could have been raised in the 1984 aggravation claim hearing, the claimant was barred from raising the same issue later.

The Supreme Court reversed. Neither issue preclusion nor claim preclusion barred the claimant from raising the wage rate issue, the court held, because the determination of the 1984 aggravation claim was not yet final:

> "A claim determination is not final until hearing and judicial review rights are barred or exhausted. The statutory scheme indicates that the finality requisite for claim or issue preclusion, against the worker, occurs only when a worker fails to timely request a hearing after a claim denial, a determination order, or a notice of claim closure, or by failure to file a timely appeal to the Board or the courts." 310 Or at 149. (Citations omitted.)

When the claimant first raised the wage rate issue, review of the 1984 aggravation claim was still pending. Therefore, the court concluded, finality had not yet attached to that proceeding, and the claimant was free to request review of the error in calculating the rate of his benefit payments. By way of contrast, the court observed that the claimant could not complain about the rate at which his temporary disability benefits had been paid under the original claim, which was closed in 1981 and from which no appeal was taken. By the time the claimant raised the wage rate issue, the 1981 order had become final. 310 Or at 150 n 13.

In the case before us, claimant had requested a hearing on the 1988 determination order, and while review was still pending, he filed his request for hearing on the wage rate issue. Claimant's challenge to the 1988 order, therefore, is identical in all material respects to the one found not barred in *Drews*. Claimant's challenge to the wage rate used to calculate his temporary total disability payments under the 1988 determination order is not barred by claim preclusion.

123 Or App 423> Claimant did not request a hearing on the 1984 determination order. At the time he filed his request for hearing on the wage rate issue, finality had attached to that order. In that respect, claimant's challenge is factually indistinguishable from the one found barred in Drews. His challenge to the wage rate used to calculate his temporary total disability benefits payments under the 1984 determination order that closed the original claim is barred by claim preclusion.

Reversed on petition and remanded for reconsideration; affirmed on cross-petition.

Cite as 123 Or App 453 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, Petitioner,
v.
MAD CREEK LOGGING, Respondent.
(SH-92021; CA A76218)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 14, 1993.

Jas. Adams, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

George Goodman, McMinnville, argued the cause for respondent. With him on the brief were Jerry K. Brown and Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

ROSSMAN, P.J.

Dismissal of citation under OAR 437-80-220(22) affirmed; reversed and remanded for reconsideration of violation of OAR 437-80-105(1).

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123 Or App 455> The Oregon Occupational Safety and Health Division (OR-OSHA), seeks review of an order of a Workers' Compensation Board referee setting aside OR-OSHA's assessment of a penalty for conduct that allegedly violated two of OR-OSHA's administrative rules, OAR 437-80-220(22) and OAR 437-80-105. The penalty is reviewable by the referee pursuant to ORS 654.078. The Workers' Compensation Board's referee's order is considered to be the final order of the Board. We reverse the Board in part, and remand for reconsideration.

Employer was hired by a third party to remove and load felled trees from some property. OR-OSHA's safety compliance officer (SCO) inspected the work site. To accomplish its job, employer used a yarder and a loader. The yarder was secured by guy wires that were wound on large spools.

OAR 437-80-220(22) provides:

> "Wire rope shall be wound on drum spools in a manner to prevent excessive wear, kinking, chafing or fouling."

The SCO inspected the spools, and noticed that the wire was wound improperly, damaging it. Employer was issued a citation for violating OAR 437-80-220(22). The parties agree that, in order to establish a violation, OR-OSHA must show that an employee was exposed to an unsafe condition as a result of a failure to comply with the standard. Employer agrees that the spool was improperly wound, but contends, and the referee found, that OR-OSHA has failed to establish a violation of the rule, because it has not presented evidence of employee endangerment. *See, e.g., Secretary v. Bechtel Corp.*, 2 OSH 1336, 1337 (1974). The referee found:

> "Here, neither the lay nor documentary evidence established any actual exposure to [employer's] employees, as a result of the improperly spooled wire. At most, defendant presented evidence that the improperly spooled wire wire [*sic*] could result in a hazzard [*sic*]. According to the testimony of Mr. David Wooley, however, even properly spooled wire could result in a hazzard [*sic*]. Wooley further testified that without performing a 'pull test,' he could not estimate the degree of damage to the wire."

123 Or App 456> OR-OSHA contends that the referee's conclusion is "legally flawed," because his analysis requires a finding of an "actual hazard," i.e., direct physical endangerment, as opposed to a potential hazard, before a citation will issue. That is not a correct reading of the referee's order. Certainly, a failure to comply with a safety rule that gives rise to a potential risk of injury to an employee is a violation, even in the absence of evidence that the employee was actually in the zone of

danger. The point of the referee's decision is that the evidence fails to show damage to the cable as a result of the violation that could create a risk to employees, either actual or potential. There is substantial evidence to support the referee's findings, and they require that the citation under OAR 437-80-220(22) be dismissed.

In his inspection of the work site, the SCO noticed that certain standing trees in the area were "wildlife trees" which were dead on top and contained dead limbs. The guy wires securing employer's yarder were in front and in back of the wildlife trees, and some of the employees were working in close proximity to the wildlife trees.

OAR 437-80-105(1) provides:

> "Danger trees within reach of landings, haul roads, rigging or work areas shall be felled *before the regular operations begin* or work shall be arranged so that employees will be constantly in the clear." (Emphasis supplied.)

The wildlife trees on employer's work site are "danger trees" within the meaning of the rule. Landings and riggings are equipment used in yarding operations. Accordingly, on its face, OAR 437-80-105(1) encompasses work sites on which yarding and loading are taking place.

OR-OSHA cited employer for yarding and loading timber in close proximity to unfelled wildlife trees. The referee set the citation aside on the ground that OAR 437-80-105(1) applies only to work sites on which timber cutting and other power saw activities are taking place. The referee based his decision primarily on the organization of the administrative rules within Division 80, which relate to the entire logging industry. The table of contents of the rules and their text are broken down into subheadings. The first subheading is entitled "General Requirements." Subsequent **<123 Or App 456/457>** subheadings deal with specific logging operations, including "Timber Cutting and Other Power Saw Usages," "Climbing Equipment, Selection and Preparation of Spars," "Rigging," "Logging Machines," "Guylines, Skylines, Spars and Anchors," "Yarding, Swinging and Loading," "Transportation," "Log Dumps and Ponds," and "Signalling and Signal Systems." The referee concluded that, because OAR 437-80-105(1) is included within a group of rules under the heading "Timber Cutting and Other Power Saw Usages," OAR 437-800-090 *et seq*, it is inapplicable to the work site here, which involved only yarding and loading operations. The referee also noted that there are rules under the heading "Yarding, Swinging, and Loading," OAR 437-80-325 *et seq*, and that one of those rules, OAR 437-80-330(11), mentions danger trees, and provides:

> "*When approaching or working around hang-ups,* employes shall approach from above the hang-up, and be alert for the danger of logs rolling or sliding, widow makers and danger trees." (Emphasis supplied.)

The referee ruled that OAR 437-80-330(11) is the controlling rule regarding danger trees, because it is more specific to the circumstances, as it is contained within the heading "Yarding, Swinging, and Loading."

We are not persuaded that it was necessary for the referee to decide which of the two rules is controlling. The rules are not inconsistent with each other or otherwise in conflict. They address different subject matters. OAR 437-80-105 states the safety precautions to be taken when danger trees are "within reach of landings, haul roads, rigging or work areas." OAR 437-80-330(11) states the precautions to be taken while working around "hang-ups." There is no indication in this record that "hang-ups" were present on employer's work site. Accordingly, OAR 437-80-330(11) is not applicable. The only question is whether OAR 437-80-105(1) is applicable to employer despite the fact that the logging operation it conducted was not timber cutting.

OR-OSHA takes the position that all of the rules within Division 80 are applicable to the logging industry generally, and that the headings of the administrative rules do not limit their applicability to specific activities. **<123 Or App 458/459>** It contends that, although when evaluating a work site OR-OSHA will look primarily to the rules regarding the specific logging operation, any rule that applies by its terms is applicable, even if it falls under a subheading that pertains to a different type of logging operation. OR-OSHA offered evidence to support its position that it considers its rules to be a unified whole and that it applies all of them, as called for by the circumstances.

Because they are not a part of the rules, rule headings are not generally relevant to determining the intentions of the drafter with respect the application of a rule. In this case, however, the headings appear to reflect OR-OSHA's attempt to organize its safety requirements on the basis of risks associated with the various types of logging operations. The referee was justified in treating the organization of the rules as bearing on their intended application. We agree with OR-OSHA, however, that the fact that a rule is within a heading for one type of operation does not necessarily exclude its application to other activities, if OR-OSHA intends that the rule apply to other aspects of logging as well, so long as that intention is not inconsistent with the express terms of the rule. Here, OAR 437-80-105(1) requires the falling of danger trees "before the regular operations begin or work shall be arranged so that employees will be constantly in the clear." Although the rule is within the group of rules relating to timber cutting operations, on its face it could apply just as readily to other operations, including employer's yarding and loading operation. OR-OSHA's intention that the rules apply to all logging operations is not inconsistent with the rule itself, or with OR-OSHA's broad authority and responsibility to adopt rules that

> "[d]eclare and prescribe what devices, safeguards or other means of protection and what methods, processes or work practices are well adapted to render every employment and place of employment safe and healthful." ORS 654.035(1).

Accordingly, we conclude that the referee erred in substituting his understanding of OR-OSHA's rules for OR-OSHA's expressed intentions with respect to the "cross-application" **<123 Or App 458/459>** of its rules. We reverse and remand for reconsideration of the alleged violation of OAR 437-80-105(1).

Dismissal of citation under OAR 437-80-220(22) affirmed; reversed and remanded for reconsideration of violation of OAR 437-80-105(1).

Cite as 123 Or App 464 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rita L. Jefferson, Claimant.

RITA L. **JEFFERSON**, Petitioner,
v.
SAM'S CAFE and SAIF CORPORATION, Respondents.
(90-22070; CA A73845)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1992.
Geoffrey G. Wren, Portland, argued the cause for petitioner. With him on the brief was Royce, Swanson & Thomas, Portland.
Steven Cotton, Special 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 Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Reversed and remanded to Board for reconsideration.
*Leeson, J., *vice* Buttler, J., retired.

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123 Or App 466> Claimant seeks review of an order of the Workers' Compensation Board holding that it and the referee had no jurisdiction to consider claimant's request for review of SAIF's refusal to act on his request for surgery.

Claimant's doctor sought authorization for surgery in June, 1990. SAIF investigated the claim and, on December 10, 1990, it asked the Director of the Department of Insurance and Finance to review the claim. On January 22, 1991, claimant requested a hearing. Before the hearing, on January 30, 1991, she had the surgery. At the time of the referee's hearing, in March, 1991, the Director had not yet issued a decision regarding the claim. In June, 1991, the referee found that the surgery was reasonable and necessary. The Board held that the referee had no jurisdiction to resolve the dispute concerning the compensability of surgery.

ORS 656.327(1) provides:

> "(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker *is receiving* medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, self-insured employer [*sic*] shall so notify the parties and the director." (Emphasis supplied.)

In *Meyers v. Darigold, Inc.*, 123 Or App 217, ___ P2d ___ (1993), we held that if any party, either the claimant or the insured, initiates the Director's review of a medical services dispute pursuant to ORS 656.327, then that process is the exclusive means of review, and the referee has no jurisdiction to consider the dispute, except under the circumstances described in ORS 656.327. We did not consider in that case whether the statute is applicable in the context of *proposed* medical treatment. The language of ORS 656.327 is clear. It expressly applies only to treatment that the claimant "is receiving" at the time the Director is asked to review the dispute. We conclude that the process of review by the Director does not apply to requests for *future* medical treatment, **<123 Or App 466/467>** and that the Hearings Division and the Board have jurisdiction to resolve disputes concerning proposed medical treatment.[1]

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[1] OAR 436-10-046(1) provides:

> "If a worker or insurer believes that the worker *has received, is receiving, or has been proposed to receive* medical treatment for a compensable condition that is excessive, inappropriate, ineffective or in violation of the medical rules and wishes review of the treatment by the director, the worker or insurer shall notify the director." (Emphasis supplied.)

We are not asked here to consider the validity of that rule.

Claimant was entitled to request a hearing on SAIF's refusal to either accept or deny her request for medical treatment. *See Barr v. EBI Companies*, 88 Or App 132, 744 P2d 582 (1987). SAIF was not entitled to have the dispute reviewed by the Director. Accordingly, the referee's decision concerning the reasonableness and necessity of the surgery was appealable to the Board, and the Board erred in concluding that it did not have jurisdiction to consider the matter.

Reversed and remanded to Board for reconsideration.

Cite as 123 Or App 468 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald J. Bidney, Claimant.

DONALD J. **BIDNEY**, Petitioner,
v.
AVISON LUMBER COMPANY and SAIF CORPORATION, Respondents.
(91-01029, 91-01028 and 91-13048; CA A74427 (control) and CA A76606) (Cases consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 24, 1993.
Richard A. Sly, Portland, argued the cause and filed the brief for petitioner.
Steven Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the briefs were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Reversed and remanded to Board for reconsideration.

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123 Or App 470> Claimant compensably injured his cervical spine in 1975 and 1976. In August, 1989, a neurosurgeon recommended surgery at C5-6 and C6-7 to correct "traumatic cervical spondylosis." SAIF neither approved nor denied claimant's request for surgery, so claimant sought assistance in obtaining approval of the surgery from the Director of the Department of Insurance and Finance (DIF). After DIF notified claimant that it had no mechanism to require SAIF to give approval of the surgery, claimant requested a hearing by a referee. Before the date set for hearing, SAIF requested that the Director review the request for medical treatment pursuant to ORS 656.327.

Referee Knapp held a hearing and issued an order in which he held that the Director of DIF had no authority to resolve a dispute for proposed medical treatment. He found that claimant's requested surgery was related to his compensable condition and was reasonable and necessary. The Workers' Compensation Board reversed the referee, holding that the Director of DIF has exclusive authority to resolve the dispute. Claimant filed a petition for review.

Pending Board review, the Director issued an order concluding that the proposed surgery was not appropriate. Claimant requested a hearing. Referee Menashe reviewed the Director's order and held that the Director had no authority to consider the medical service dispute, but determined, on an advisory basis only, that the Director's decision was supported by substantial evidence. Referee Menashe vacated the Director's order. SAIF appealed that order to the Board, and the Board held that the Director has exclusive jurisdiction of the dispute and that the Director's order was supported by substantial evidence. The Board reinstated the Director's order. Claimant filed a second petition for review. The petitions have been consolidated for our review.

In *Jefferson v. Sam's Cafe*, 123 Or App 464, ___ P2d ___ (1993), we held that ORS 656.327(1) is inapplicable to proposed medical treatment. Accordingly, the Board erred in concluding in its first order that the Director has exclusive jurisdiction to resolve this dispute. The Board's first and **<123 Or App 470/471>** second orders are reversed; the referees' orders are reinstated; the case is remanded to the Board for reconsideration of SAIF's appeal of the order of Referee Knapp.[1]

Reversed and remanded to Board for reconsideration.

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[1] In the light of our disposition of this case, we do not consider claimant's contention that the Board erred in failing to assess a penalty and attorney fee for SAIF's failure to refer the dispute to the Director within 90 days of the claim.

Cite as 123 Or App 472 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James E. Niccum, Claimant.

JAMES E. **NICCUM**, Petitioner,
v.
SOUTHCOAST LUMBER CO. and SAIF CORPORATION, Respondents.
(90-17616; CA A73922)

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.
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 Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.
ROSSMAN, P.J.
Reversed and remanded for reconsideration of claim for medical services; otherwise affirmed.
*Leeson, J., vice Buttler, J., retired.

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123 Or App 474> Claimant seeks review of a Workers' Compensation Board order dismissing a portion of his appeal of an order of the referee on the ground that the Director of the Department of Insurance and Finance has exclusive jurisdiction to determine whether claimant's proposed medical treatment is reasonable and necessary.

The Board relied on its decision in *Stanley Meyers*, 43 Van Natta 2643 (1991), and its interpretation of ORS 656.327 and ORS 656.704. In *Meyers v. Darigold, Inc.*, 123 Or App 217, ___ P2d ___ (1993), we reversed the Board's decision in Stanley Meyers, and held that the referee has jurisdiction to consider medical treatment disputes, so long as no party has requested review by the Director pursuant to ORS 656.327. In *Jefferson v. Sam's Cafe*, 123 Or App 464, ___ P2d ____ (1993), we held that the referee's authority includes the power to consider *all* disputes concerning *proposed* medical treatment, because those disputes are not subject to ORS 656.327(1). Accordingly, we remand the case to the Board for it to consider claimant's appeal on its merits.

Claimant also seeks review of that portion of the Board's order holding that he has failed to establish an aggravation of his compensable injury. ORS 656.273(1) provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

The Board held that "there was a lack of objective findings of a worsened condition." Claimant contends that the statute requires only that the medical evidence be supported by objective findings, and that the Board has erroneously required that the worsening itself be shown by objective findings. The argument is a semantic maneuver. There is no substantive difference between the statutory language that the worsening be shown by medical evidence supported by objective findings and the Board's language that the worsening be shown by objective medical findings. We agree with the **<123 Or App 474/475>** Board that, under the statute, objective medical evidence of a worsening is required in order to establish an aggravation claim, and we conclude that the Board's finding that claimant has not established a worsening is supported by substantial evidence.

Reversed and remanded for reconsideration of claim for medical services; otherwise affirmed.

Cite as 123 Or App 498 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY AND HEALTH DIVISION, Respondent,

v.

DON WHITAKER LOGGING, INC., Petitioner.

(SH-91182; CA A74704)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 3, 1993.

George W. Goodman, McMinnville, argued the cause for petitioner. With him on the brief were Jerry K. Brown and Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Deits, Presiding Judge, and Rossman and Riggs, Judges.

DEITS, P.J.

Affirmed.

Rossman, J., dissenting.

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123 Or App 500> Employer seeks review of an order of the Workers' Compensation Board that denied a request for attorney fees and costs on the ground that the Board lacked authority to make such an award.[1] We affirm.

The parties do not dispute the facts. Following a fatality investigation of employer's premises by the Occupational Safety and Health Division (OSHD), employer was issued three citations for violations of the Oregon Safe Employment Act. Employer requested a hearing to challenge the validity of the citations. ORS 654.078. At the hearing, employer conceded the validity of one of the citations and moved to dismiss the other two. The Board dismissed the two citations but denied employer's request for attorney fees and costs on the basis that it lacked authority to make such an award.[2] The Board subsequently denied reconsideration. Neither party seeks review of the Board's decision on the merits. Employer assigns as error the Board's conclusion that it lacked authority to award attorney fees and costs to employer. We review to determine whether the Board erroneously interpreted a provision of law. ORS 183.482(8)(a).

As a general rule, costs and attorney fees are not recoverable absent a statute or contractual provision authorizing them. *Stelljes/Dumler v. State Board of Parole*, 307 Or 365, 769 P2d 177 (1989). The Oregon Safe Employment Act grants jurisdiction to the Board over contested citation hearings, ORS 654.078(1), but does not authorize the Board to award attorney fees to a prevailing party. Absent this express statutory authority, the Board did not have the authority to grant employer's request.

Employer argues that the Board's rule authorizing it to "[t]ake any * * * action necessary for a full and fair disposition of the case" expressly authorizes it to award attorney fees. OAR 438-85-805(12). However, even assuming this rule could be read to authorize an award of attorney fees, it would not provide the necessary authority. The Board's **<123 Or App 500/501>** powers are limited to those delegated to it by statute. *U. of O. Co-Oper. v. Dept. of Rev.*, 273 Or 539, 550, 542 P2d 900 (1975). Where, as here, the statute does not authorize an award, the agency cannot create that authority by administrative rule.

Employer next argues that the Board had discretion to award attorney fees under the "equitable exception" to the general rule. The basis of that exception is the inherent power of courts of equity to award attorney fees in some circumstances, even in the absence of specific statutory authority. *Deras v. Myers*, 272 Or 47, 66, 535 P2d 541 (1975). Administrative agencies, however, are creatures of statute and do not have the powers of a court of equity. Rather, they are limited to the authority conferred on them

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[1] Employer seeks review of the original order issued by the Board on March 2, 1992, as well as the Board's order issued on reconsideration on October 9, 1992.

[2] The Board invalidated both citations for inadequate documentation of OSHD's investigation.

by statute. *See Ochoco Const. v. DLCD*, 295 Or 422, 426, 667 P2d 499 (1983). The Board did not err in denying employer's request for attorney fees and costs.

Affirmed.

ROSSMAN, J., dissenting.

Because I would award employer attorney fees, I dissent.

OOSHD's safety compliance officer (SCO) inspected employer's work site after a fatal accident. The SCO documented suspected violations, summarized his findings and made recommendations. The SCO forwarded his papers to his supervisor for review. Two pages, including the summation and recommendations, were irretrievably discarded by the SCO's supervisors before copies were sent to employer. The SCO was instructed to produce acceptable replacements. OOSHD subsequently issued a citation based on the recreated documentation. The Board's referee held that the investigation of that violation was invalid due to OOSHD's failure to provide investigative documents to employer.

The referee found that the equities weigh in favor of an award of attorney fees, a determination that has never been challenged. However, the referee declined to award attorney fees, on the ground that he lacked authority to do so in the absence of a specific statutory provision authorizing an award of fees.

123 Or App 502> The Board's administrative rule, OAR 438-85-805(12), essentially confers on the referee the same kind of equitable powers as possessed by the circuit court, this state's court of general jurisdiction. It provides:

> "It is the duty of the Referee to conduct a fair and impartial Hearing and avoid delay. The Referee has the authority to:
> "* * * * *
> "(12) *Take any other action necessary for full and fair disposition of the case.*" (Emphasis supplied.)

In my view, the rule, which permits the referee to "take any action" necessary for *full and fair* disposition of the case, would certainly permit the referee to make an award of attorney fees under the circumstances of this case. I recognize that such a determination is contingent on whether such power exists in the Board. As the majority has said, the Board's authority to award attorney fees must come from the statutes, not administrative rules. It then concludes that there is no statute authorizing an award of fees in this case, and that the Board has no inherent power to award attorney fees. Accordingly, despite the broad reach of the administrative rule, the referee has no authority to award fees.

I look at it somewhat differently. Any time we have the opportunity to salvage a rule that directs the bureaucracy to be fair, I believe we should give that rule every reasonable chance to succeed. Although it is true that there is no statute expressly allowing the award of attorney fees in this kind of case, that does not end the inquiry.

The legislature has delegated to the Department of Insurance and Finance, and to the Workers' Compensation Board specifically, broad authority to accomplish its purpose of enforcing and ensuring compliance with the Oregon Safe Employment Act. *See* ORS 654.003. Under ORS 654.025(5), the Board has authority to

> "do and perform all things whether specifically designated in [the Oregon Safe Employment Act] or in addition thereto, which are necessary or convenient in the exercise of any power, authority or jurisdiction conferred."

That delegation implicitly includes many of the equitable powers possessed by courts, and authorizes the Board to **<123 Or App 502/503>** promulgate rules such as OAR 438-85-805, which is broad enough to encompass an award of attorney fees. I would hold that, included among the Board's authority is the power to award attorney fees when such an award is necessary to ensure compliance with the Act or to make a full and fair disposition of the case. Here, an attorney fee is appropriate as a sanction against OOSHD for its failure to comply with the Act and the rules promulgated thereunder, and would be consistent with the express policy of the legislature. Compare ORCP 17. Because I conclude that the statutes authorize such an award of fees, I would reverse the Board and remand the case for reconsideration.

Cite as 123 Or App 585 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

MILDRED **OWEN**, Appellant,
v.
POZZI, WILSON, ATCHISON, O'LEARY AND CONBOY, a partnership, and DAVID A. HYTOWITZ, Respondents.
(90 CV 0505; CA A71547)

Appeal from Circuit Court, Coos County.
Richard L. Barron, Judge.
On appellant's petition for reconsideration filed July 7, 1993. Opinion filed June 2, 1993. 120 Or App 580, 853 P2d 314.
Charles Robinowitz, Portland, for petition.
Frank A. Moscato and Moscato, Byerly & Skopil, Portland, contra.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
DE MUNIZ, J.
Reconsideration allowed; opinion modified and adhered to as modified.

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123 Or App 587> Treating plaintiff's petition for review as one for reconsideration of our opinion, 120 Or App 580, 853 P2d 314 (1993), we allow the petition, modify our opinion and adhere to it as modified.

Plaintiff sued defendants for legal malpractice for failing timely to file a request for a hearing on the workers' compensation claim of plaintiff's deceased husband. A jury awarded her damages of $192,000. On appeal, plaintiff argued that the trial court erred in denying her "Motion to Increase Judgment" in the amount of $16,015 as interest. In our opinion, we held that plaintiff waived the right to any claim to interest when she did not object to the court's removing the issue from the jury.

We agree with plaintiff that we erred in relying on *Langfus, Inc. v. Queirolo*, 64 Or App 493, 497, 668 P2d 1245, *rev den* 296 Or 237 (1983), in which a general verdict was submitted to the jury under ORCP 61A. Here, the jury was given a special verdict under ORCP 61B. However, the special verdict does not assist plaintiff.

The gravamen of plaintiff's position is that the amount of certain benefits due to her is readily ascertainable; therefore, *ipso facto*, she is entitled to interest on those amounts. In her petition for reconsideration, she insists that the issue was solely a matter of law. She contends that

> "the trial court told the jury it was removing the issue of interest or damages for loss of use of funds from its consideration. No party objected, and subsequently, the court made a legal ruling that the plaintiff was not entitled to interest. If the court had submitted a general verdict to the jury, Langfus might be relevant, but the trial court submitted a special verdict with this issue expressly omitted. The trial court complied with ORCP 61B. in deciding this issue, and the plaintiff waived nothing."

In her petition for reconsideration, for the first time she argues that our decision in *Robertson v. Jessup*, 117 Or App 460, 845 P2d 926 (1992), controls and is in conflict with our holding here. In that legal malpractice action, we held that a down payment and monthly payments that were due **<123 Or App 587/588>** on known dates were ascertainable amounts on which prejudgment interest should have been awarded. She insists:

> "When a plaintiff in a legal malpractice case proves that because of her lawyer's negligence, she was deprived of a specific amount of money by a specific date, the trial court is compelled to award her damages for loss of use of those funds as a matter of law."

We do not agree that Robertson requires an award of interest as the issue was tried here. Even if plaintiff is correct that the trial court could have awarded interest on past benefits, it cannot be ascertained from the special verdict whether the jury awarded them.

Plaintiff's position is that once the jury determined that decedent was permanently and totally disabled, it had no discretion in determining the amount of certain benefits. However, that is not the way the issue was presented to the jury. In her opening and responding briefs, plaintiff acknowledged that her "claim was not exactly prejudgment interest" but, rather, was "an element of damage":

> "This Court should note that the plaintiff is not claiming she would have been entitled to interest on her underlying workers' compensation benefits. That is, she is not claiming interest on the money SAIF would have owed her to September 1, 1988. * * *
>
> "[Plaintiff] is claiming interest to compensate her for the loss of use of the funds which she would have received no later than September 1, 1988, had the defendants performed competently. Mallen and Smith in their treatise, *Legal Malpractice*, recognize the validity of this claim.
>
> "'Interest, as an element of damage, may be recoverable in two situations. First the client may be entitled to recover interest if but for the attorney's negligence the client would have received interest in the underlying litigation or transaction. Second, interest may be awarded to compensate the client for the loss of the use of funds which would have been received had the attorney performed competently....'

"Mallen and Smith, *Legal Malpractice*, (Third Ed. 1989), 16.5, p. 897."

Plaintiff's complaint alleged damages in the sum of $385,041. At trial, she presented evidence regarding what the **<123 Or App 588/589>** interest would be on benefit amounts decedent would have received to the date of his death; on benefit amounts that plaintiff and the children would have received while the children were under age 18; and on benefit amounts plaintiff would have received after her children reached the age of 18 to June, 1991. However, also as part of damages, she claimed the loss of future benefits. Her expert testified that damages totalled $385,041.

The trial court withdrew the issue of interest from the jury, and plaintiff did not object; however, the special verdict did not identify the components of her claim for damages. Rather, the jury was asked to award a lump sum: "What are plaintiff's permanent total disability damages?" In the blank next to that question, the jury wrote the single figure of "$192,000." After the verdict, plaintiff filed her motion claiming interest on benefits other than future benefits.

Plaintiff's damage claim was composed of amounts, some of which could be subject to prejudgment interest and some of which could not. It is not possible to determine from the verdict whether the jury awarded damages for benefits upon which prejudgment interest was claimed or, if it did, whether it awarded all that plaintiff asked for. The amounts are not ascertainable. The trial court did not err in denying plaintiff's motion to increase judgment.

Reconsideration allowed; opinion modified and adhered to as modified.

Cite as 123 Or App 590 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE OF OREGON, by and through **Director of the Department of Insurance and Finance**, Appellant,
v.
HAROLD **BRIMHALL**, dba The Dalles Transmission Specialties, Respondent.
(CC91-86; CA A74649)

Appeal from Circuit Court, Wasco County.
Donald W. Hull, Judge.
Argued and submitted February 17, 1993.
Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for appellant. With her on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Jay W. Beattie, Portland, argued the cause for respondent. With him on the brief was Lindsay, Hart, Neil & Weigler, Portland.
Before Deits, Presiding Judge, and Riggs and Durham, Judges.
DURHAM, J.
Reversed and remanded.

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123 Or App 592> The Department of Insurance and Finance (DIF), appeals from a summary judgment for defendant and the denial of DIF's cross-motion for summary judgment on DIF's claim for costs of processing a non-compensable claim. We reverse.

A subject worker employed by defendant filed a claim for workers' compensation. ORS 656.017. DIF determined that defendant was a noncomplying employer, ORS 656.052, and referred the claim to SAIF, which initially accepted it. ORS 656.054(1). Defendant did not challenge the non-compliance determination, but requested a hearing on SAIF's acceptance. The referee and the Board determined that the claim was fraudulent. DIF reimbursed SAIF for the costs of processing and investigating the claim, and brought this action to recover those costs from defendant. ORS 656.054(3). In its motion for summary judgment, defendant argued that DIF may recover the administrative costs of processing a claim only if the claim is compensable.

The version of ORS 656.054 applicable to these proceedings provided, in part:

> "(1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. The director shall refer the claim for such injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer * * *.
>
> "* * * * *
>
> "(3) In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Industrial Accident Fund of a claim processed under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, reasonable administrative costs and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Insurance and Finance Fund. The director shall recover such costs from the employer. The director shall provide by regulation for the Insurance and Finance Fund to reimburse, on a periodic **<123 Or App 592/593>** basis, the Industrial Accident Fund for any costs it incurs under this section."[1]

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[1] ORS 656.054(1) has since been amended by Oregon Laws 1991, chapter 679, section 1.

The statute supports DIF's position that "all costs" of a claim processed under subsection (1) are a liability of the noncomplying employer. Recoverable costs are not limited to those attributable to a claim that is compensable. ORS 656.054(1) provides for the processing of every

> "claim for compensation made by such a [subject] worker [employed by a noncomplying employer] * * * in the same manner as a claim made by a worker employed by a carrier-insured employer * * *."

Processing a claim under ORS 656.054(1) includes determining whether the claim is compensable. The cost of investigating a claim to determine whether it is compensable is a liability of the non-complying employer even if, as here, the insurer later rejects it because it is fraudulent. Had the legislature intended to allow recovery only for costs incurred in the processing of compensable claims, it could have said so. *See* ORS 656.054(2); ORS 656.735(3) (limiting the imposition of civil penalties against a noncomplying employer to cases where the subject worker suffers a compensable injury).

DIF also assigns error to the denial of its cross-motion for summary judgment. Because genuine issues of material fact remain in connection with that motion, it was not error to deny it.

Reversed and remanded.

Cite as 123 Or App 623 (1993) October 6, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pamela J. Panek, Claimant.

PAMELA J. **PANEK**, Petitioner,
v.
OREGON HEALTH SCIENCES UNIVERSITY and SAIF CORPORATION, Respondents.
(91-11126; CA A76255)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 14, 1993.

Kevin Keaney, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

PER CURIAM

Reversed and remanded for consideration of compensability of home-health care; otherwise affirmed.

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123 Or App 624> Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's decision ordering SAIF to pay for claimant's home-health care and awarding claimant an attorney fee under ORS 656.382(1). In the light of our decision in *Meyers v. Darigold, Inc.*, 123 Or App 217, ___ P2d ___ (1993), in which we held that the Board has jurisdiction to consider medical treatment disputes if no party has requested that the Director of the Department of Insurance and Finance resolve the dispute, we reverse and remand the case to the Board for it to consider the merits of the compensability of the home-health care.

Claimant also contends that the Board erred in affirming the referee's decision that the proper rate of reimbursement for claimant's treatment team is a dispute concerning medical fees that is within the jurisdiction of the Director, rather than a matter concerning a claim, within the jurisdiction of the Board. We agree with the Board that the question is within the jurisdiction of the Director. ORS 656.704(3); ORS 656.248(13); *see Haynes v. Weyerhaeuser Co.*, 75 Or App 262, 706 P2d 567, *rev den* 300 Or 332 (1985).

Reversed and remanded for consideration of compensability of home-health care; otherwise affirmed.

Cite as 124 Or App 161 (1993) October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JAMES E. **THOMPSON**, Petitioner,
v.
EMPLOYMENT DIVISION, Respondent.
(92-AB-1920; CA A77685)

Judicial Review from Employment Appeals Board.
Argued and submitted July 9, 1993.
Jeremy V. Sarant argued the cause for petitioner. With him on the brief was Lewis and Clark Legal Clinic.
Philip Schradle, Assistant Attorney General, waived appearance for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Affirmed.

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124 Or App 163> Claimant seeks judicial review of an order of the Employment Appeals Board (EAB) denying his request for an extension of his base year, ORS 657.170, for purposes of calculating unemployment benefits. We affirm.

Claimant sustained a back injury at work on May 16, 1988. After taking nine days off work because of that injury, he returned and continued to work until September 15, 1989, when the injury precluded any further work. He filed for workers' compensation benefits under ORS chapter 656, and was declared temporarily totally disabled (TTD) from September 15, 1989, to September 18, 1991. He was declared medically stationary on September 25, 1991, and received a notice of claim closure on November 20, 1991.

Claimant sought and received reconsideration of the claim closure. His TTD was extended to November 6, 1991. The amended notice of claim closure was not issued until May 27, 1992.

On June 10, 1992, claimant filed a claim for unemployment benefits.[1] The Division denied the claim on the ground that claimant had not worked during his base year of January to December 31, 1991, and therefore did not satisfy the conditions of ORS 657.150(2).[2] The Division also held that claimant had failed to timely file for a base year extension under ORS 657.170(2). Claimant requested a hearing on the denial. The referee upheld the denial and claimant appealed to EAB, which affirmed.

ORS 657.170(2) provides that, if an individual has had a period of TTD caused by illness or injury and has received workers' compensation during the greater part of any calendar quarter, the base year may be extended up to a maximum of four calendar quarters prior to the quarter in which the illness or injury occurred, if the individual

124 Or App 164> "(a) Files a claim for benefits not later than the fourth calendar week of unemployment after the end of the period of temporary total disability described in this subsection; and

"(b) Files such a claim within the three-year period immediately following the commencement of such period of illness or injury."

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[1] The record does not indicate either the circumstances under which or the date on which claimant became unemployed.

[2] ORS 657.150(2) provides, in part:

"To qualify for [unemployment] benefits an individual must have worked 18 or more weeks in subject employment in the base year wit total base year wages of $1,000 or more."

In holding that claimant's claim, filed on June 10, 1992, did not satisfy the statute because claimant's TTD had ended on November 6, 1991, EAB explained:

> "[W]e are bound by the unambiguous language of ORS 657.170(2)(a). That provision requires claimant to file his claim 'not later than the fourth calendar week of unemployment *after the end of the period of temporary total disability* * * *,' not after the date of any notice provided by the Workers' Compensation Division." (Emphasis in original.)

Claimant does not challenge EAB's interpretation of the statute.[3] He contends that, as applied, ORS 657.170(2)(a) violates Article I, section 20, of the Oregon Constitution,[4] because the requirement to file a claim within four weeks of the cessation of TTD arbitrarily classifies claimants on the basis of whether they are notified of claim closure prior to the expiration of the four week period.[5]

Claimant is incorrect that the statute classifies persons on the basis of when they receive notification of claim closure. The statute classifies on the basis of whether claimants file their claims within the prescribed period. The statute does not violate Article I, section 20, by creating a uniformly applicable limitation period for filing claims. *See, e.g., Sealey* **<124 Or App 164/165>** *v. Hicks*, 309 Or 387, 397, 788 P2d 435, cert den 498 US 819 (1990).

Affirmed.

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[3] Claimant notes that HB 2132 was introduced in the 1993 legislature to "remedy the problem he now faces." That bill was in conference committee when the legislature adjourned.

[4] Article I, section 20, of the Oregon Constitution provides:

> "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

Claimant raises no federal constitutional claims.

[5] Claimant also assigns error to the referee's determination that he failed to satisfy the requirements of ORS 657.170(2)(b). He asks us to construe that provision to mean that the three-year period for requesting a base year extension runs from the date that a claimant begins receiving TTD, rather than from the date of injury. We do not address that assignment, because EAB's decision was not based on that subsection.

Cite as 124 Or App 220 (1993) November 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

GARY **NEHER**, Personal Representative of the Estate of Julie Neher, Deceased, Appellant,
v.
LARRY LEE **CHARTIER** and TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON, a municipal corporation, doing business under the assumed business name of Tri-Met, Respondents.
(A9112-08001; CA A75617)

Appeal from Circuit Court, Multnomah County.
Robert W. Redding, Judge.
Argued and submitted April 7, 1993.
Elden M. Rosenthal argued the cause for appellant. With him on the briefs were B. Carlton Grew and Rosenthal & Greene, P.C.
John R. Faust, Jr., argued the cause for respondents. With him on the brief was Schwabe, Williamson & Wyatt.
Before Warren, Presiding Judge, and Edmonds and Leeson, Judges.
WARREN, P.J.
Affirmed.

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124 Or App 222> Plaintiff appeals from a judgment dismissing his complaint for wrongful death. We affirm.

Plaintiff is the personal representative of the estate of his adult daughter, who was killed when she was crushed beneath a bus while crossing a street in the course of her employment. The bus was operated by defendant Tri-County Metropolitan Transportation District of Oregon (Tri-Met) and driven by defendant Chartier, Tri-Met's employee. Plaintiff claims that defendants were negligent in various particulars. He gave timely notice of the claim under the Oregon Tort Claims Act (OTCA). ORS 30.260 *et seq.* Defendants moved for judgment on the pleadings, ORCP 21B, on the basis of immunity under ORS 30.265(3)(a), for claims covered by workers' compensation. The trial court granted the motion.[1] Plaintiff makes two assignments of error, both relating to the ruling on that motion.

This case involves the interaction of the wrongful death statute, the OTCA and the workers' compensation statutes. The wrongful death statute, ORS 30.020, allows the personal representative of the estate to maintain an action against an alleged tortfeasor, for the benefit of the decedent's legal heirs, if the decedent could have maintained an action had she lived. A claim against a governmental body such as Tri-Met is limited by ORS 30.265, which provides for immunity of the public body and its officers, employees and agents who are acting within the scope of their employment, for any claim for death of a person covered by any workers' compensation law. ORS 30.265(3)(a). Finally, under ORS 656.204, workers' compensation death benefits are limited to $3,000 for burial expenses if the decedent is an adult over 21 years old who has no spouse, children or other dependents. Defendants do not challenge plaintiff's assertion that, as a result of **<124 Or App 222/223>** the interaction of those statutes, the total compensation for plaintiff's daughter's death is $3,000.

ORS 30.265 provides, in part:

> "(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:

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[1] In his first assignment, plaintiff appears also to challenge what he asserts is the granting of Chartier's separate motion to dismiss, which was based on ORS 30.265(1). The motion for judgment on the pleadings, made by both defendants, was based on ORS 30.265(3). That is the motion on which the court ruled and the basis on which it dismissed the complaint. The court did not rule on Chartier's separate motion to dismiss. Furthermore, the provisions of ORS 30.265(1) that plaintiff asserts are unconstitutional were not in effect until after the date alleged in the complaint as the date of decedent's death. *See* Or Laws 1991, ch 861, 1. Accordingly, we will not consider plaintiff's challenge to ORS 30.265(1).

> "(a) Any claim for injury to or death of any person covered by any workers' compensation law."

Plaintiff first argues that that statute violates Article I, section 10, of the Oregon Constitution, which provides that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation." Plaintiff asserts that the immunity provided to public bodies and their employees by ORS 30.265(3)(a) denies him a remedy for decedent's death. He acknowledges the rule that the legislature may alter or abolish a cause of action,

> "so long as the party injured is not left entirely without a remedy. Under those cases, the remedy need not be precisely of the same type or extent; it is enough that the remedy is a substantial one." *Hale v. Port of Portland*, 308 Or 508, 523, 783 P2d 506 (1989).

However, he relies primarily on the concurrence in *Hale*, in which Judge Linde said:

"[T]he court has allowed legislative immunization of cities from tort liability only on condition that the individuals who are personally responsible for harm qualifying as a legal injury remain liable. *Batdorff v. Oregon City*, 53 Or 402, 100 P 937 (1909); *Mattson v. Astoria*, 39 Or 577, 65 P 1066 (1901)." 308 Or at 530.

Because, under the workers' compensation scheme, the only payment provided for the death of plaintiff's daughter is $3,000 burial expenses, ORS 656.204(1), plaintiff argues that the immunity granted by ORS 30.265(3)(a) essentially deprives him of any substantial remedy.

Defendants counter that the protection of Article I, section 10, applies only to rights established at common law, *see Stewart v. Houk et al.*, 127 Or 589, 271 P 998, 272 P 893 (1928), and that wrongful death is a statutory, not a common law, remedy. They argue that, because the right to recover for the death of another did not exist at common law when the **<124 Or App 223/224>** Oregon Constitution was adopted, the legislature can limit or eliminate entirely the cause of action. Even applying the *Hale* substantial remedy standard, defendants argue that the workers' compensation system provides an alternative, albeit different, remedy for the death of plaintiff's decedent. Plaintiff replies first that *Stewart* is no longer authoritative, having been implicitly overruled by *Perozzi v. Ganiere*, 149 Or 330, 40 P2d 1009 (1935), and that, even if Article I, section 10, protects only rights recognized at common law in 1859, an action for wrongful death was one of those rights.

We need not decide whether Article I, section 10, applies only to protect rights that existed at common law at the time of the adoption of the Oregon Constitution or, if that is true, whether an action for wrongful death was recognized as a common law right. Even assuming that Article I, section 10, applies to plaintiff's claim, his argument fails. Under the analysis set out by the majority of the court in Hale, a legislative alteration of a cause of action is permissible, as long as the injured party is "not left entirely without a remedy. * * * [T]he remedy need not be precisely of the same type or extent; it is enough that the remedy is a substantial one." 308 Or at 523.[2] We are not unaware of plaintiff's claim that $3,000 in burial costs is little remedy for the loss of his daughter's life. However, we cannot say that the substitution of that remedy under the workers' compensation system for any remedies he would otherwise have had against Tri-Met or its driver, is a complete denial of a substantial remedy. As the court said in *Hale*:

> "This may not be what plaintiff wants. It may not even be what this court, if it were in the business of making substantive law on this subject, would choose to enact. But it is within the legislature's authority to enact in spite of the limitations of Oregon Constitution, Article I, section 10." 308 Or at 523.

Plaintiff next argues that ORS 30.265(3)(a) violates Article I, section 20, by granting immunity to officers, employees and agents of public bodies. Section 20 provides:

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[2] Even *Mattson v. Astoria, supra*, cited by Judge Linde in his concurrence, recognizes that a remedy may be changed or substituted, so long as the injured person is not denied a remedy entirely. 39 Or at 580. Here, there is a remedy under the workers' compensation system.

124 Or App 225> "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

Plaintiff makes two separate challenges under that section: that the statute unconstitutionally denies to nondependent parents the privilege of recovering for the wrongful death of a child killed by the employee of a public body, and that it unconstitutionally grants an immunity to a class of citizens, employees of public bodies, that is not equally available to all employees.

Defendants make three threshold arguments. They first assert that plaintiff's argument that employees of a public body constitute a class under Article I, section 20, was not made to the trial court and that, therefore, it was not preserved for appeal. Even assuming that the specific argument had to be raised, see *State v. Hitz*, 307 Or 183, 766 P2d 373 (1988), the argument was preserved. Plaintiff made the argument in his memorandum in response to Chartier's motion to dismiss. Although the trial court did not specifically rule on that motion, the argument was presented, and we will address it.

Second, they argue that the estate, of which plaintiff is the personal representative, is not a citizen entitled to invoke the protections of Article I, section 20. *See Van Wormer v. City of Salem*, 309 Or 404, 408 n 7, 788 P2d 443 (1990). Finally, they argue that plaintiff cannot make out a constitutional violation, because he has not alleged that he has suffered harm because of the denial of a privilege or immunity that is granted to others.

We need not decide whether an estate may invoke the protection of Article I, section 20, or whether plaintiff needs to show harm from the denial to him of the privilege or immunity that he challenges, because, in any event, there is no Article I, section 20, violation by ORS 30.265(3)(a). Section 20 prohibits the government from providing special treatment to favored individuals or classes of citizens. *Hale v. Port of Portland, supra*, 308 Or at 524-25.[3] That prohibition **<124 Or App 225/226>**

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[3] We share plaintiff's frustration in attempting to discern the correct analysis for Article I, section 20, challenges. The Supreme Court's opinions have been inconsistent regarding what is a "true class." In *State v. Clark*, 291 Or 231, 240, 630 P2d 810, *cert den* 454 US 1084 (1981), the court said that classes are based on personal characteristics that persons or groups have apart from the law itself, such as sex, ethnic background, legitimacy, residency or military service. In *Hale v. Port of Portland, supra*, 308 Or at 525, the court applied a similar standard to hold that a classification of victims of governmental torts is not an identifiable class, because it is not based on "antecedent personal or social characteristics or societal status." However, in *Sealey v. Hicks*, 309 Or 387, 788 P2d 435, *cert den* 498 US 819 (1990), the court held that persons injured by products do constitute a class for purposes of Article I, section 20, because the class exists apart from the statute. *Compare Van Wormer v. City of Salem, supra* (persons who suffered governmentally inflicted wrongful death not true class); *Eckles v. State of Oregon*, 306 Or 380, 387, 760 P2d 846 (1988), *cert dismissed* 490 US 1032 (1989) ("'classes' of private insurers, insureds and [workers' compensation] claimants on the one hand, and SAIF insureds and claimants on the other," are not true classes); *Norwest v. Presbyterian Intercommunity Hosp.*, 293 Or 543, 652 P2d 318 (1982) (children of disabled parents not a class under Article I, section 20); with *State ex rel Adult & Fam. Ser. v. Bradley*, 295 Or 216, 666 P2d 249 (1983) (illegitimacy is a true class); *Hewitt v. SAIF*, 294 Or 33, 653 P2d 970 (1982) (gender is a true class). The court also has not been clear about what analysis applies if there is a "true class" involved. *Compare Hewitt v. SAIF, supra* (gender classification reviewed for whether it was based on intrinsic differences between the sexes) with *Seto v. Tri-County Metro. Transportation Dist.*, 311 Or 456, 814 P2d 1060 (1991) (geographic classification reviewed for rational basis) and *Hale v. Port of Portland, supra*, 308 Or at 524 (rational basis test "has been superseded"). Further, it is unclear whether there is any judicial scrutiny at all if the class not a "true class," but is created by the statute itself. *See, e.g., Sealey v. Hicks, supra*, 309 Or at 397 (classes "created by the challenged law itself" are "entitled to no special protection and, in fact, are not even considered to be classes for the purposes of Article I, section 20"); *Hale v. Port of Portland, supra*, 308 Or at 525 (victims of governmental torts are not an identifiable class based on personal or social characteristics and, therefore, there is no violation of Article I, section 20); *Eckles v. State of Oregon, supra*, 306 Or at 387 (classes that exist only by virtue of the statute do not violate Article I, section 20); but *see State v. Clark, supra*, 291 Or at 240 (attacks on classes created by the legislative scheme itself have generally been rejected whenever the law leaves it open to anyone to join); *Cole v. Dept. of Rev.*, 294 Or 188, 655 P2d 171 (1982) (law not directed at true class passed Article I, section 20, challenge because the privilege was available upon the same terms equally to all citizens); *Hunter v. State of Oregon*, 306 Or 529, 761 P2d 502 (1988) (grant of post-conviction relief to persons convicted of a state crime but not to persons convicted of a municipal crime is a classification created by the statute itself, but it does not violate Article I, Section 20, because the same standard applies to all).

applies to invalidate the granting of a privilege or immunity to a class of citizens[4] only when the class is a "true class," *i.e.* one defined by characteristics apart from the law, not "by the challenged law itself." *State v. Clark, supra n* 3, 291 Or at 240.

Plaintiff argues that, as to the grant of the privilege of recovery of damages for wrongful death by a decedent's estate, the statute is constitutionally infirm because it treats **<124 Or App 226/227>** parents of a decedent differently from other wrongful death plaintiffs. *See Zockert v. Fanning*, 310 Or 514, 800 P2d 773 (1990); *Young v. Alongi*, 123 Or App 74, ___ P2d ___ (1993); *but see Norwest v. Presbyterian Intercommunity Hosp., supra* n 3. We disagree that the classification is based on parenthood. ORS 30.265(3)(a) does not treat parents differently from nonparents. It treats claims for injury or death caused by governmental bodies or their agents differently from claims for injury or death caused by other potential tortfeasors.[5] Thus, plaintiff is in exactly the same situation as were the plaintiffs in *Hale v. Port of Portland, supra,* and *Van Wormer v. City of Salem, supra.* The OTCA classifies those entitled to recover for injuries by who the defendant is. As the court said in *Van Wormer*, the reasoning of *Hale*

> "applies equally here: Those persons who have suffered a governmentally-inflicted wrongful death are merely a subset of those who have suffered wrongful death at the hands of tortfeasors generally. The subset exists only because the statutory scheme of which it is a part exists. The subset is not based on any *ad hominem* characteristic, such as race, sex or religious affiliation, of the subset's members. There is no reason for this court to treat the subset differently in the constitutional analysis. *Hale v. Port of Portland, supra; cf. Norwest v. Presbyterian Intercommunity Hosp.* [*supra* n 3] (Oregon Constitution Article I, section 20, not violated because law permits recovery on behalf of a child for wrongful death of a parent but not for wrongful injury short of death, although child may be equally deprived of parent's society and companionship in either case)." 309 Or at 408.

There is no constitutional violation based on the granting of the privilege to bring a claim only to those persons injured by tortfeasors other than officers, employees or agents of public bodies.

Plaintiff also argues that ORS 30.265(3)(a) is unconstitutional to the extent that it grants an immunity to employees of public bodies, but not to employees of other, nongovernmental employers. That argument fails for the **<124 Or App 227/228>** same reason that the privileges argument does: The classification, i.e., employees of public bodies, is one created by the statute; it is not a class based on "antecedent personal or social characteristics or societal status." *Hale v. Port of Portland, supra*, 308 Or at 525; *see also, e.g., Van Wormer v. City of Salem, supra; State v. Freeland*, 295 Or 367, 375, 667 P2d 509 (1983).[6] Because the classification is created by the OTCA itself, it is not subject to Article I, section 20, scrutiny.[7]

The trial court did not err in dismissing the claim.

Affirmed.

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[4] Plaintiff does not argue that the statute grants a privilege or immunity to any individual citizen.

[5] Indeed, the statute applies only if the injury is covered by the Workers' Compensation Law. We rejected an Article I, section 20, challenge to that classification in *Jungen v. State of Oregon*, 94 Or App 101, 764 P2d 938 (1988), *rev den* 307 Or 658, *cert den* 493 US 933 (1989).

[6] Even if the classification could be cognizable under Article I, section 20, it appears that judicial scrutiny is limited to whether the classification is rational, because the classification is not based on any invidious social category. *See Seto v. Tri-County Metro. Transportation Dist., supra* n 3; *Sealey v. Hicks, supra* n 3; but *see Hale v. Port of Portland, supra*, 308 Or at 524. We cannot say that a legislative choice to extend immunity to government employees whose actions cause injury to persons covered by workers' compensation is irrational, especially in light of the public employer's obligation to indemnify its officers, employees and agents for alleged acts or omissions occurring in the performance of their duties. See ORS 30.285(1).

Although the concurrence in *Krieger v. Just*, 117 Or App 64, 76-77, 843 P2d 473 (1992), *rev allowed* 316 Or 142 (1993), argued that the immunity provided to public employees constituted both a "true class" and was arbitrary, the arguments in this case, which are directed specifically at those questions, convince us otherwise. Further, that comment in Kreiger was about ORS 30.275(1), which is not at issue in this case.

[7] Plaintiff does not argue that there should be any judicial scrutiny under Article I, section 20, if the classification is created by the statute itself, rather than a class that exists apart from the statute. *See* n 3, *supra.*

Cite as 124 Or App 558 (1993) November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

HUBERT B. **FINCH**, Appellant,
v.
RAY **ANDREWS**, THE NATIONAL HOT ROD ASSOCIATION, a California corporation, and John Does 1-15, Respondents.
(91-2042-L-1; CA A78081)

Appeal from Circuit Court, Jackson County.
L. A. Merryman, Judge.
Argued and submitted September 17, 1993.
Robert S. Hamilton argued the cause for appellant. With him on the brief was Frohnmayer, Deatherage, Pratt, Jamieson & Turner, P.C.
Hugh B. Collins argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Leeson and Landau, Judges.
DE MUNIZ, J.
Affirmed.

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124 Or App 560> Plaintiff sued defendants Andrews, who was the driver of a dragster, and the National Hot Rod Association (NHRA) to recover damages for personal injuries sustained during a drag race. He appeals from a summary judgment in favor of defendants. ORCP 47. We affirm.

We review the record in the light most favorable to plaintiff, the party opposing defendants' motion for summary judgment. *Poirier v. United Grocers, Inc.*, 110 Or App 592, 594, 824 P2d 1158, *rev den* 313 Or 210, 820 P2d 596 (1992). Plaintiff, a seasonal Jackson County employee, worked as a track starter for the Jackson County Sports Park drag strip on two weekends a month during the racing season. He was employed elsewhere on a full-time basis.

Jackson County had a contract with NHRA, under which NHRA would provide personnel, coordination and supervision at the drag races. In order to continue employment at the drag strip, Jackson County required that plaintiff sign a release and waiver contract (release). The release relieved NHRA, Andrews and others from liability for negligent acts causing injury to plaintiff. During a race, a dragster driven by Andrews struck and injured plaintiff.

The trial court granted defendant's motion for summary judgment on the ground that plaintiff had assumed the risk of injury when he signed the release. On appeal, plaintiff contends that the release is void as a matter of public policy. Defendants argue that release contracts are valid unless they fall under a recognized public policy exception and that no such exception applies here.

Plaintiff does not dispute that, as a general rule, release contracts are upheld unless they contravene public policy.[1] *See, e.g., Poirier v. United Grocers, Inc., supra.* He argues, however, that, when such agreements are made between employers and employees, they are against public policy. *K-lines v. Roberts' Motor Co.*, 273 Or 242, 249, 541 P2d 1378 (1975); Restatement (Second) Contracts 195(2)(a) **<124 Or App 560/561>** (1981). He also contends that such agreements should be void when employers require their employees to release third parties from liability.

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[1] A public policy must be "overpowering" before a court will interfere with the parties' freedom to contract. *Young v. Mobil Oil Corp.*, 85 Or App 64, 69, 735 P2d 654 (1987).

Defendants counter that the release does not contravene public policy. They acknowledge that, under earlier law, agreements between employees and employers releasing the latter from liability were held invalid as against public policy. Defendants argue, however, that the rationale behind those cases, which was that employers subjected their employees to economic coercion, no longer applies. They claim that employers can no longer exploit their employees, because employees have more rights against employers than they did in the past, for example, workers compensation laws, ORS chapter 656. Accordingly, defendants argue that, because the rationale supporting the public policy exception between employers and employees has weakened, we should not extend the reach of the public policy exception to benefit those who were not parties to the contract.

We need not decide whether defendants' criticism of the rationale behind employer-employee liability release contracts has merit, because here the rationale by which those contracts were found to be against public policy does not apply. Plaintiff's employer did not place him at an unfair disadvantage or leave plaintiff with no other alternative than to sign the agreement, because his job at the drag strip was not his means of livelihood. At the summary judgment proceeding, there was evidence that plaintiff worked at the drag strip for only a few hours per month for a few months per year. He voluntarily chose to work at the drag strip, even though he had a full-time job elsewhere, because he was an avid racing hobbyist. It appears that plaintiff's main purpose for working at the drag strip was to gain access to the restricted racing area. Employer's requirement that he sign the agreement in order to continue the employment did not place plaintiff at an unfair disadvantage sufficient to violate public policy. Summary judgment was proper.

Affirmed.

Cite as 125 Or App 396 (1993) December 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Anne M. Maley, Claimant.

STEVEN E. **TIMM**, D.M.D., Petitioner,
v.
ANNE M. **MALEY**; SAIF CORPORATION; SAIF CORPORATION (NCE); and CNA INSURANCE COMPANIES, Respondents.
(WCB Nos. 91-09137, 90-06629, 91-03931 and 91-02379; CA A77804)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 15, 1993.
James L. Edmunson argued the cause for petitioner. With him on the brief was Neil R. Bryant.
David W. Hittle argued the cause and filed the brief for respondent Anne M. Maley.
Steven Cotton, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation (NCE). With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Jerald P. Keene argued the cause for respondent SAIF Corporation. With him on the brief were Darren L. Otto and Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C.
Charles L. Lisle argued the cause for respondent CNA Insurance Companies. With him on the brief were Gene Platt and Cummins, Brown, et al.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Motion to dismiss denied; reversed and remanded for reconsideration of responsibility.

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125 Or App 398> Steven E. Timm, D.M.D., the noncomplying employer (Timm (NCE)), seeks review of an order of the Workers' Compensation Board, contending that the Board erred in concluding that SAIF, acting in its capacity as processing agent for Timm (NCE), (SAIF (NCE)), is responsible for claimant's compensable occupational disease, rather than CNA Insurance Companies, which insured Timm before Timm became noncomplying.

Because the hearing in this case was convened on June 20, 1990, the law in effect before the 1990 amendments to the Workers' Compensation Law applies. Or Laws 1990 (Special Session), ch 2, 54(2).

Beginning October, 1986, Timm was insured by CNA. From March 18, 1988, through September 22, 1988, Timm was noncomplying. Beginning September 23, 1988, SAIF insured Timm. Initially, we deny SAIF's motion, made in its capacity as Timm's insurer following the period of noncompliance, that the petition should be dismissed because Timm (NCE) did not serve the Attorney General, as required by ORAP 4.15(5)(b). The record shows service on an assistant attorney general on behalf of SAIF (NCE). That is sufficient to comply with the requirement of ORAP 4.15(5)(b).

Claimant has a history of back injuries, not work related. From October, 1983, to May, 1989, she worked for Timm on and off as a dental technician. In July, 1987, claimant developed significant pain and numbness in her left leg and foot. On September 25, 1987, she began receiving treatment from Dr. Mann, an osteopath. He diagnosed hypermobile left sacroiliac with chronic left sacroiliac ligament sprain and secondary low back tightness. He believed that claimant's condition was probably exacerbated by her work as a dental technician. Claimant's condition gradually worsened.

On May 16, 1988, Mann recommended that claimant reduce her work hours. Beginning in mid-May, claimant worked part time because of her back condition. On June 14, 1988, claimant filed a claim with Timm. During July, claimant was off work entirely because of her back.

125 Or App 399> CNA denied the claim on the grounds that the claim had not been timely filed and that CNA was not the insurer at the time of the injury. The Department of Insurance and Finance (DIF) issued an order that Timm was a noncomplying employer, which Timm did not contest. It forwarded the claim to SAIF for processing by SAIF on behalf of Timm (NCE). Claimant requested a hearing on CNA's denial.

On June 28, 1989, the referee issued an order stating that the parties had resolved the claim and that SAIF (NCE) had agreed to accept it. The claim against SAIF (NCE) was closed by a determination order dated September 26, 1989. The order showed the "date of injury" as September 25, 1987, and awarded claimant temporary partial disability, "less any time worked," from September, 1987, through August 9, 1989, and 13 percent permanent partial disability. No party appealed the determination order, and it became final.

Timm (NCE) filed a request for hearing, challenging the compensability of the claim and the assignment of responsibility to SAIF (NCE). Timm (NCE) moved to join CNA as a necessary party. The Board, in affirming the referee, held that the claim is compensable and assigned responsibility to SAIF (NCE).

The only question on review is responsibility. Timm (NCE) contends that the unappealed September, 1989, determination order conclusively established that claimant actually became disabled in September, 1987, while Timm was insured by CNA, and that CNA is therefore responsible. The order lists the date of injury as September 25, 1987, and awards temporary partial disability beginning September, 1987, less any time worked. Assuming that the date of injury stated in the order could have any bearing on this occupational disease claim, it has no necessary relationship to the date of disability, and is not dispositive with respect to when claimant actually became disabled. Also, the fact that the order makes an award of temporary partial disability from a specific date does not resolve the question of when claimant actually became disabled, in light of the fact that the award is expressly limited to those periods when claimant was not working, but does not specify what those dates were.

125 Or App 400> Timm (NCE) contends, further, that claimant's condition is the responsibility of CNA because claimant received treatment for the condition while Timm was insured by CNA. Citing *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), the Board stated the general principle that the date of disability, rather than the date of the first medical treatment, determines which employer is responsible. In *Bracke*, the claimant was employed by successive employers as a meat cutter. Her last employer was Thriftway. During her previous employment with Baza'r, she began to experience asthmatic symptoms which disabled her and for which she sought medical care. After leaving Baza'r and becoming employed by Thriftway, the claimant's condition was diagnosed as "meat packer's asthma." The claimant filed claims against each of her employers, including Baza'r and Thriftway. Thriftway was assigned responsibility for the claim, as the employer who could have caused the condition; as a practical matter, however, responsibility could not be assigned to Thriftway, because the claimant had not appealed its denial of the claim. The Supreme Court held that the claimant proved that her employment at Baza'r had actually caused the condition and that the condition had resulted in disability while she was employed at Baza'r. Accordingly, the court held that Baza'r could not shift responsibility to a subsequent employer by showing that the subsequent employment "could have" contributed to the condition.

In discussing the application of the last injurious exposure "rule of liability" in the context of an occupational disease, the Supreme Court said:

> "Under the last injurious exposure rule of assignment of liability in cases of successive employment, each of which has contributed to the totality of the disease, the potentially causal employer at the time disability occurs is assigned liability for the cumulative whole.[4]

> "4. Arguably, given the wording of ORS 656.005(8),[1] above, the date when symptoms necessitate medical treatment could also be deemed a triggering date for liability or a **<125 Or App 400/401>** substitute for proof of causation. Because claimant suffered disabling symptoms when she first sought medical treatment, we need not examine the effect to be given to the date of first treatment." 293 Or at 248.

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[1] At the pertinent time, the definition of "compensable injury" was contained in ORS 656.005(8), and included the language, now in ORS 656.005(7), that a compensable injury "arises out of and in the course of employment requiring medical services or resulting in disability[.]"

As the Supreme Court's footnote suggests, because the claimant in *Bracke* was disabled at the time she first sought medical treatment, there was no reason for the court to consider how initial responsibility for the claim might have been assigned had the claimant experienced a need for medical treatment before leaving work due to the condition. However, we have addressed that question in at least three cases: *SAIF v. Luhrs*, 63 Or App 78, 663 P2d 418 (1983); *SAIF v. Harris*, 63 Or App 256, 663 P2d 1307, *rev den* 295 Or 730 (1983); and *SAIF v. Gupton*, 63 Or App 270, 663 P2d 1300 (1983). The rule to be drawn from those decisions is that, if a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition.

Because it held that the date claimant first left work was dispositive for the purpose of assigning responsibility for the claim, the Board did not decide expressly when claimant's treatments became compensable or whether claimant's employment subsequent to her first compensable treatment contributed independently to the cause of the condition. We remand to the Board for it to make that determination.

Motion to dismiss denied; reversed and remanded for reconsideration of responsibility.

Cite as 125 Or App 454 (1993) December 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lonnie F. Scheller, Claimant.

LONNIE F. **SCHELLER**, Petitioner,
v.
HOLLY HOUSE and SAIF CORPORATION, Respondents.
(WCB 92-00964; CA A79200)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 18, 1993.
Stanley Fields argued the cause for petitioner. With him on the brief was Michael B. Dye.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Deits, Presiding Judge, and Riggs and Durham, Judges.
RIGGS, J.
Reversed and remanded for reconsideration.

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125 Or App 456> Claimant seeks review of an order of the Workers' Compensation Board holding that medical reports, prepared after an order on reconsideration, were inadmissible in a hearing before a referee. We review for substantial evidence and errors of law, ORS 656.298(6) and ORS 183.482(8), and reverse.

Claimant injured her right knee on May 18, 1990. A determination order on July 30, 1991, awarded no permanent partial disability. A January 17, 1992, an order on reconsideration affirmed the determination order. On reconsideration, no one disagreed with the impairment used in rating claimant's disability, and no medical arbiter was requested or appointed. Claimant subsequently requested a hearing. At the hearing, she introduced two medical exhibits that were prepared after the order on reconsideration. Based on those exhibits, the referee awarded claimant 5 percent permanent partial disability. SAIF appealed the referee's award, claiming that the two exhibits were inadmissible; the Board agreed and reversed the referee. Claimant seeks review of the Board's order, arguing that the exhibits were admissible before the referee.

The procedures a referee uses when conducting a hearing are set out in ORS 656.283. ORS 656.283(7) provides, in part:

> "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. * * * Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing * * *."

SAIF argues that a claimant's right to present evidence is limited by ORS 656.268(7), which provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. At the request of either of the parties, a panel of three medical arbiters shall be appointed. * * * **<125 Or App 456/457>** The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for the purpose of making findings of the impairment on the claim closure."

SAIF contends that under that provision no medical information obtained after the reconsideration process is admissible before the Board or courts on the issue of impairment.

In *Pacheco-Gonzales v. SAIF*, 123 Or App 312, 860 P2d 822 (1993), a medical arbiter's report was ordered, but not completed until after the order on reconsideration. The Board, in that case found that the referee could not consider the arbiter's report at the hearing. We reversed the Board and held that ORS 656.208(7) "prohibits the admission of evidence developed *after* the medical arbiter's report." Where, as here, no medical arbiter was appointed, the limitation in ORS 656.268(7) does not apply. The applicable statute is ORS 656.283(7), which contains no such limitation on a worker's right to submit evidence. *Safeway Stores, Inc. v. Smith*, 122 Or App 160, 163, 857 P2d 187 (1993). Under these circumstances and under ORS 656.283(7), the medical reports were admissible.

Reversed and remanded for reconsideration.

Cite as 125 Or App 520 (1993) December 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael R. Wickstrom, Claimant.

MICHAEL R. **WICKSTROM**, Petitioner,
v.
NORPAC FOODS, INC., Respondent.
(91-11489; CA A79216)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 3, 1993.
Max Rae argued the cause and filed the brief for petitioner.
John E. Pollino argued the cause for respondent. With him on the brief were Chess Trethewy and Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.
Before Rossman, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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125 Or App 522> Claimant seeks review of a Workers' Compensation Board order holding that the Board lacks jurisdiction to conduct a hearing when a Department of Insurance and Finance (DIF) order on reconsideration was issued without first having reviewed a medical arbiter's report, and also that the Board may not consider that report. In *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 860 P2d 822 (1993), we held that the Board has jurisdiction to conduct a hearing regardless of whether DIF reviewed a medical arbiter's report, and that, under ORS 656.268(7), the Board should review the report even if DIF did not. We write only to clarify the effect of the 1991 statutory amendments on whether the Board should review medical arbiter's reports.

ORS 656.268(7) provides:

> "The findings of the medical arbiter * * * shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

In 1991, the legislature added language to the statute, codified at ORS 656.268(6)(a):

> "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." Or Laws 1991, ch 502, 1.

The amendments apply to requests for reconsideration made "on and after October 1, 1991." Or Laws 1991, ch 502, 2.

In this case, a medical arbiter's report was prepared after DIF had issued its order on reconsideration. On review, claimant asked the referee to consider the medical arbiter's report anyway. The referee declined to do so, because claimant had requested reconsideration on May 7, 1991, before the effective date of ORS 656.268(6)(a). In *Pacheco-Gonzalez*, however, we held that the Board is required to consider medical arbiter's reports under ORS 656.268(7), which was not amended in 1991. We noted that the enactment of the new language in ORS 656.268(6)(a) supported our interpretation of ORS 656.268(7), but that the unamended statute remained the basis for our decision. 123 Or App at 316. Therefore, the **<125 Or App 522/523>** Board should consider the medical arbiter's report, even if claimant requested reconsideration on or before October 1, 1991.

Reversed and remanded for reconsideration.

Cite as 125 Or App 536 (1993) December 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael E. Cooney, Claimant.

MICHAEL E. **COONEY**, Petitioner,
v.
SAFEWAY STORES, INC., Respondent.
(91-12106; CA A78682)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 12, 1993.

Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.

Kenneth L. Kleinsmith argued the cause for respondent. With him on the brief was Meyers & Radler.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Reversed and remanded with instructions to remand to the Director of the Department of Consumer and Business Services.

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125 Or App 538> Claimant seeks review of a Workers' Compensation Board order denying him additional benefits for permanent partial disability for impairment due to chondromalacia, a disability not covered by standards existing at the time of the order on reconsideration. We reverse and remand.

Claimant suffered a compensable knee injury in 1986 and underwent three major surgeries. Because of the injury, he suffers chondromalacia of the patella. He was declared medically stationary on January 29, 1991. A determination order issued on August 28, 1991, did not make a separate award for that impairment. Claimant requested a hearing, and the referee also did not make a separate award for chondromalacia.

In June, 1992, the Director of the Department of Insurance and Finance[1] promulgated a rule providing for an impairment award for chondromalacia. OAR 436-35-230(13)(a)-(b). On claimant's appeal, the Board evaluated and denied his claim under the new rule. It held that the report of claimant's physician, written on August 9, 1991, ten months before the rule was adopted, was "not persuasive evidence" because it was "not in conformance with the requirements of OAR 436-35-230(13)(a)-(b)." That was error. OAR 438-10-010(2) provides that, "[f]or claims in which the claimant was medically stationary after July 1, 1990, the disability rating standards in effect on the date of issuance of the reconsideration order shall be applied at hearing and on review of the reconsideration order." On August 29, 1991, the date of the reconsideration order, there were no standards for rating claimant's chondromalacia impairment. The Board should have remanded the case to the Director of the Consumers and Business Services to adopt the requisite rule. *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 542, ___ P2d ___ (1993).

Reversed and remanded with instructions to remand to the Director of the Department of Consumer and Business Services.

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[1] The Department of Insurance and Finance is now called the Department of Consumer and Business Services.

Cite as 125 Or App 549 (1993) December 29, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joan E. Hathaway, Claimant.

JOAN E. **HATHAWAY**, Petitioner,
v.
HEALTH FUTURE ENTERPRISES and SAIF CORPORATION, Respondents.
(WCB 90-21435; CA A72995)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 23, 1992.
Karen M. Werner argued the cause for petitioner. With her on the brief were J. David Kryger and Emmons, Kropp, Kryger, Alexander, Egan & Allen.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

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125 Or App 551> Claimant seeks review of a Workers' Compensation Board order holding that the Board did not have jurisdiction to determine whether claimant's proposed palliative chiropractic treatment is compensable. We affirm.

After claimant became medically stationary and her claim was closed, her attending physician sought approval from employer's insurer, SAIF, for proposed palliative chiropractic treatment, pursuant to ORS 656.245(1)(b). That paragraph provides, in part:

> "[A]fter the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. 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 [of the Department of Insurance and Finance] for such treatment. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment."

SAIF denied the request. The physician did not request approval from the director. Claimant sought a hearing on SAIF's denial.

The referee approved the request for palliative care. On appeal, the Board vacated the referee's order, holding that it did not have jurisdiction to consider the compensability of the proposed palliative treatment. It explained that the Board has jurisdiction over matters concerning a claim and that, under ORS 656.704(3), a matter concerning a claim does not include any dispute regarding medical treatment for which a procedure for resolution is otherwise provided in ORS chapter 656. The Board relied on its decision in *Stanley Meyers*, 43 Van Natta 2463 (1991), in which it had concluded that a **<125 Or App 551/552>** medical treatment dispute that may be resolved by the director under the procedures set out in ORS 656.327(1)(a) is not a matter concerning a claim under ORS 656.704(3), and therefore jurisdiction over the compensability of that treatment is within the exclusive jurisdiction of the director.

In this case, the Board applied similar reasoning. It held that the appropriateness of palliative treatment is not a matter concerning a claim over which the Board has jurisdiction, because ORS 656.245(1)(b) provides a procedure for the resolution of that dispute. Therefore, it held that the director has exclusive jurisdiction over the compensability of the palliative care.

Since the Board's order in this case, we reversed the Board's decision in *Stanley Meyers. Meyers v. Darigold, Inc.*, 123 Or App 217, 861 P2d 352 (1993). We held that ORS 656.327(1)(a) is not a mandatory review procedure. That paragraph provides:

> "If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer or self-insured employer shall so notify the parties and the director."

ORS 656.327(1)(a) was enacted in 1987, and gave the parties a choice whether to seek director review of certain medical treatment disputes or to request a hearing. When ORS 656.704(3) was amended in 1990, the definition of "matters concerning a claim" was changed to exclude any proceedings "for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." ORS 656.327(1)(a) was not substantively amended. We concluded in *Meyers* that the 1990 amendments to ORS 656.704(3) did not alter the voluntary nature of the procedure provided in ORS 656.327(1)(a) or make it the exclusive means of resolving a dispute concerning medical treatment. Because the purpose of the definition of "matters concerning a claim" in ORS 656.704(3) is to determine the respective authority of the director and the Board, we held that, if no party invokes the director's authority under ORS **<125 Or App 552/553>** 656.327(1)(a), then the conditions necessary to confer exclusive jurisdiction on the director do not exist, there is no question of respective authority, and the Board has jurisdiction to resolve the dispute.

Here, the dispute centers on ORS 656.245(1)(b), which governs compensability of palliative care. That paragraph was a new provision added by the same 1990 legislative act that amended ORS 656.704(3). It differs significantly from ORS 656.327(1)(a). Under ORS 656.245(1)(b), palliative care is not generally compensable. If, however, the claimant's attending physician believes that the palliative care is necessary to allow the claimant to continue current employment, the statute provides a single avenue for obtaining compensation for that care: The physician must request approval from the insurer and, if the insurer does not grant the approval, the physician may request approval from the director. Without approval, the care is not compensable. Approval can be obtained only by invoking the procedure provided by ORS 656.245(1)(b). Unlike medical treatment disputes covered by ORS 656.327(1)(a), there is no alternative method for review of an insurer's decision not to approve compensation for palliative care. We conclude that the procedure provided in ORS 656.245(1)(b) is the exclusive procedure available for contesting the insurer's decision not to approve palliative care, and that it is a matter within the exclusive jurisdiction of the director. The Board was correct in holding that it did not have jurisdiction to resolve the dispute.

Affirmed.

Cite as 125 Or App 580 (1993) December 29, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Wanda L. Rowe, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
WANDA L. **ROWE**, Respondent.
(WCB 91-08657; CA A80060)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1993.
H. Scott Plouse argued the cause for petitioner. On the brief were Adam T. Stamper and Cowling & Heysell.
David C. Force argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Affirmed.

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125 Or App 581> In this worker's compensation case, claimant made a claim for an occupational disease, which she described as "[w]orking over number of year [sic], numbness, tingling, ect [sic] on putty machine for 17 years." She described the nature of the disease as "carpel [sic] tunnel." The referee concluded that the condition was not compensable. On review, the Board reversed, holding that claimant's "upper extremity" condition was compensable. The Board's order is not entirely clear, because it finds an upper extremities condition compensable, when the claim was for carpal tunnel syndrome. Regardless of how the Board characterized the condition, there is no dispute that there is substantial evidence to support a finding that the condition for which claimant sought compensation, carpal tunnel syndrome, was caused in major part by claimant's employment. We understand the Board's order to decide no more than that claimant's carpal tunnel syndrome is compensable. Accordingly, we affirm.

Affirmed.

Cite as 125 Or App 608 (1994) January 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

NINA **CLEVIDENCE**, Guardian Ad Litem for Randy C. Olesen, a Minor, Appellant,
v.
PORTLAND SCHOOL DISTRICT #1, Respondent.
(9202-00733; CA A76242)

Appeal from Circuit Court, Multnomah County.
Lee Johnson, Judge.
Argued and submitted July 29, 1993.
David C. Force argued the cause and filed the briefs for appellant.
Thomas W. McPherson argued the cause for respondent. With him on the brief was Peter R. Mersereau.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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125 Or App 610> Plaintiff appeals a judgment for defendant Portland School District No. 1, in this action brought under the Oregon Tort Claims Act. Plaintiff is the conservator and guardian ad litem for Randy Olesen, her minor grandson. Randy was injured in the cafeteria at Lewis Elementary School, operated by defendant, where Randy was a fourth-grader. At the time of the accident, Randy was working to put away tables in the cafeteria as a participant in the school district's "cafeteria assistance program," under which students may work in the cafeteria and receive free lunch. A table fell on him and seriously injured his right leg.

Plaintiff brought this personal injury action against defendant on behalf of Randy, alleging that Randy's injuries were due to defendant's negligence. Plaintiff assigns error to the trial court's granting of defendant's motion for summary judgment. The court held that, because Randy was an employee of the district, his exclusive remedy is under the Workers' Compensation Law and that defendant is immune from liability pursuant to ORS 30.265(3)(a):

> "Every public body [is] * * * immune from liability for:
>
> "(a) Any claim for injury to or death of any person covered by any workers' compensation law."

Randy's father had given written consent for Randy to work in the lunchroom. The consent form stated that "students are covered by State Accident Insurance while working in the lunchroom." The school district is self-insured, pursuant to ORS 656.017. Defendant submitted evidence on summary judgment that, at the time of the accident, it had elected pursuant to ORS 656.039 to provide workers' compensation coverage to students participating in the cafeteria assistance program and had paid workers' compensation premiums to itself for that coverage. It submitted evidence that the assessments were calculated by determining the total number of student workers in the district's schools for a given quarter and multiplying that number by the value of the meal provided to the participants as consideration for their cafeteria work. Defendant determined that Randy was entitled to workers' compensation coverage and paid medical benefits to him.

125 Or App 611> Plaintiff contends that the immunity of ORS 30.265(3)(a) does not apply, because Randy was not a covered worker, as he was under the age of 14 and could not be legally employed, see ORS 653.320,[1] and he did not have the legal ability to enter a contract for employment. Further, she contends, as a matter of public policy, under the circumstances here defendant should not be granted immunity under ORS 30.265(3).

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[1] ORS 653.320(1) provides, in part:

> "No child under the age of 14 shall be employed in any work or labor for wages or other compensation to whomsoever payable, during the term when the public schools of the * * * district * * * in which the child resides are in session."

We need not address plaintiff's contentions concerning the legality of Randy's employment. The coverage of the Workers' Compensation Law extends to all persons who fall within the definition of the term "worker." ORS 656.005(28) defines "worker" as

> "any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *."

The definition expressly includes minors, whether lawfully or unlawfully employed. Under Oregon law, a minor, although illegally employed, is still entitled to the benefits of the workers' compensation system, and those benefits are exclusive. *Manke, Adm'x v. Nehalem Logging Co.*, 211 Or 211, 219-23, 301 P2d 192, 315 P2d 539 (1957). Accordingly, plaintiff's argument that defendant unlawfully employed minor children is irrelevant to the determination of whether Randy was a worker entitled to benefits under the Workers' Compensation Law. If the other requirements of ORS 656.005(28) are satisfied, Randy is a worker for purposes of workers' compensation, despite his age or the legality of his employment relationship.

Plaintiff contends that the lunches that Randy received are not, as a matter of law, "remuneration" under the statute, because Randy had "an absolute statutory right to receive a free school lunch whether he furnished his services to Defendant or not." Plaintiff offered no evidence, nor has she cited any authority, in support of her position **<125 Or App 611/612>** that defendant was mandated by law to provide lunches to Randy. We reject the contention that the lunches could not, as a matter of law, be remuneration. *See Buckner v. Kennedy's Riding Acad.*, 18 Or App 516, 526 P2d 450 (1974).

Plaintiff contends that, even if Randy was a worker for purposes of workers' compensation, he was excluded from coverage under ORS 656.027. We need not decide that question. ORS 656.039(1) provides:

> "An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. * * * If the employer is or becomes a self-insured employer, the election shall be made by filing written notice thereof with the director, the effective date of coverage to be the date specified in the notice."

Throughout this proceeding, defendant has maintained that it elected to provide coverage for Randy pursuant to that section.

For the first time on appeal, plaintiff argues that there is no evidence that defendant's election was procedurally correct. We disagree with plaintiff's assessment of the record. Defendant presented uncontradicted evidence that, pursuant to ORS 656.039(1), it elected to and did provide workers' compensation coverage for plaintiff. Plaintiff submitted no evidence or counter affidavit that defendant's election was incomplete or ineffective.

Plaintiff further contends that there is an issue of fact as to whether Randy's injuries arose out of and in the course of his employment. Plaintiff does not direct us to any specific part of the record to establish such an assertion. However, we have reviewed all of the record and conclude that there is no question of fact as to whether Randy was in the course of his employment at the time of the injury.

For the first time on appeal, plaintiff makes several arguments concerning the constitutionality of ORS 30.265(3) as applied to injured student workers. We will not address them.

The trial court properly granted defendant's motion for summary judgment.

Affirmed.

Cite as 125 Or App 661 (1994) January 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sandie K. Driver, Claimant.

SANDIE K. **DRIVER**, Petitioner,
v.
ROD & REEL RESTAURANT and SAIF CORPORATION, Respondents.
(90-12482; CA A74250)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 25, 1992.
Edward J. Harri argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondent. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Reversed and remanded for reconsideration.

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125 Or App 663> Claimant seeks review of an order of the Workers' Compensation Board that reduced the referee's award of scheduled disability on the ground that no physician measured claimant's impairment. We review for errors of law, ORS 656.298; ORS 183.482(8)(a), and reverse.

Claimant was a food service worker. Employer closed her claim for bilateral carpal tunnel syndrome[1] and awarded 16 percent unscheduled permanent partial disability, but no scheduled disability.[2] Claimant requested a hearing. The referee increased the award of unscheduled disability and awarded 28 percent scheduled permanent partial disability for claimant's right wrist, based on a licensed physical therapist's measurements of lost grip strength and reduced active dorsiflexion. *Former* OAR 436-35-005(1) (since renumbered OAR 436-35-005(5) by WCD Admin Order 2-1991) provided, in part:

> "'Impairment' means a decrease in the function of a body part or system as measured by a physician * * *."

The Board reduced the award of scheduled disability, reasoning that the physical therapist was not a physician.[3]

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[1] Former ORS 656.268(3)(a) (since amended and renumbered 656.268(4)(a) by Or Laws 1990, ch 2, 16), provided:

> "When the worker's condition has become medically stationary and the worker has returned to work, the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Insurance and Finance."

[2] OAR 436-35-005 provides, in part:

> "(7) 'Scheduled Disability' means a permanent loss of use or function which results from injuries to those body parts listed in ORS 656.214(2)(a) through (4) [arm, leg, foot, toe, hearing, vision, hand, thumb, finger].
>
> "(8) 'Unscheduled Disability' means the permanent loss of earning capacity due to a compensable on the job injury or disease as described in these rules, arising from those losses * * * not to body parts or functions listed in ORS 656.214(2)(a) through (4)."

[3] The Board sustained the portion of the disability attributable to reduced active dorsiflexion only because employer failed to challenge those measurements.

ORS 656.005(12)(a) defines a "physician" as

> "a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate."

125 Or App 664> The Board's interpretation of the term "physician" in the rule must comport with the policy that inheres in the statutory definition of that term. *Cook v. Workers' Compensation Department*, 306 Or 134, 138, 758 P2d 854 (1988). The question is whether physical therapy is one of the "healing arts." In *Cook*, the Supreme Court held that the term "healing arts"

> "would be commonly understood as the skill to treat disease or disability and, where the nature of the problem permits, to restore to health." 306 Or at 143.

Cook held that a nurse practitioner's qualification "to provide comprehensive, independent medical care in the form of diagnosis, treatment, advice and referrals" falls "within the commonly understood meaning of a 'healing art.'" 306 Or at 143. Employer argues that physical therapists do not "provide comprehensive, independent medical care" like nurse practitioners. However, they do practice a healing art within the Supreme Court's definition in *Cook*. ORS 688.010 defines physical therapy, in part, as:

> "the evaluation, *treatment* and instruction of a human being *to assess, prevent, correct, alleviate and limit* the signs and symptoms of *physical disability, bodily malfunction and pain.*" ORS 688.010. (Emphasis supplied.)

Under that definition, a physical therapist treats a patient's physical disability and, where the nature of the problem permits, restores the patient to health. The Board erred in concluding that a physical therapist does not satisfy the definition of "physician" in ORS 656.005(12).

Employer argues, in the alternative, that the Board's order should be affirmed, because it found that the physical therapist failed to attribute claimant's lost grip strength to "atrophy, anatomical changes, or nerve damage" due to the compensable injury as required by the version of OAR 436-35-110(3) (since amended by WCD Admin Order 2-1991), applicable to the proceedings. The Board concluded:

> "The record does not show that any physician measured claimant's grip strength or attributed any loss of grip strength to nerve damage, atrophy or other anatomical change due to claimant's compensable condition."

125 Or App 665> That statement is ambiguous. We cannot discern whether the Board would have reached the same result but for its erroneous conclusion that a physical therapist is not a "physician." The Board can address that ambiguity on remand.[4]

Reversed and remanded for reconsideration.

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[4] We do not address whether ORS 656.245(3)(b)(B) applies to this dispute, because it was not discussed by the Board in its order, or briefed by the parties on appeal.

Cite as 125 Or App 666 (1994) January 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arlene J. Koitzsch, Claimant.

ARLENE J. **KOITZSCH**, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and AGRIPAC, INC., Respondents.
(90-13984; CA A74860)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 10, 1992.
Linda C. Love argued the cause and filed the brief for petitioner.
James D. McVittie, Appellate Counsel, Liberty Northwest Insurance Corporation, argued the cause and filed the brief for respondents.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Reversed and remanded for reconsideration.

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125 Or App 668> Claimant seeks review of an order of the Workers' Compensation Board that rejected her claim for additional disability compensation. She contends that the Board erred in considering the findings of a doctor who was not her treating physician. We review for errors of law, ORS 656.298(6); ORS 183.482(8), and reverse.

The referee awarded claimant, a former cannery worker, 34 percent permanent partial disability for her carpal tunnel syndrome. The degree of disability included impairment from loss of sensation. Claimant's physician, Dr. Johnson, found that claimant suffered from a total loss of sensation. Employer referred claimant to Dr. Nathan, who found only a partial loss of sensation. Nathan also criticized many of Johnson's findings. The referee relied on Nathan's impairment findings in awarding 34 percent disability.

Claimant appealed to the Board, arguing that ORS 656.245(3)(b)(B) allows consideration only of the impairment findings by her attending physician for purposes of evaluating her disability. That subparagraph provides, in 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."[1]

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[1] One of the disability rating procedures "otherwise provided" by chapter 656 is the provision for arbiters to resolve all disagreements over the rating of disability in the claim closure. ORS 656.268 provides, in part:

> "(4) * * *
>
> "* * * * *
>
> "(e) If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section.
>
> "* * * * *
>
> "(7) If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. At the request of either of the parties, a panel of three medical arbiters shall be appointed. * * * The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

125 Or App 669> The Board concluded that the referee improperly based his disability award on Nathan's findings, but reasoned that employer could use those findings "for purposes of supporting or impeaching the opinion and ratings offered by Dr. Johnson." The Board concluded that Johnson's findings of impairment were not reliable and that claimant, consequently, had failed to meet her burden to prove entitlement to a greater disability award. The Board affirmed the referee's award, because employer did not argue that it should be reduced. Claimant assigns error to the Board's reliance on Nathan's impairment findings, because he was not the attending physician.

Our goal in interpreting the statute is to discern the legislative intent. ORS 174.020; *Porter v. Hill*, 314 Or 86, 91, 838 P2d 45 (1992). We look first to the statute's text and context. If those sources do not disclose the legislature's intent, we resort to legislative history. *Bartz v. State of Oregon*, 314 Or 353, 357, 839 P2d 217 (1992).

ORS 656.245(3)(b)(B) is ambiguous, because it is capable of more than one reasonable interpretation and does not expressly foreclose use of an independent medical examiner's findings for impeachment. The context of the statute does not indicate the legislature's intended meaning. Therefore, we look to legislative history. ORS 656.245(3)(b)(B) was added during the 1990 special session. Or Laws 1990, ch 2, 10. One goal of the special committee that considered the comprehensive changes to the workers' compensation laws in 1990 was to reduce the costs created by independent medical examinations. Representative Bob Shiprack of the special committee explained:

> "There's also some dramatic cuts in litigation costs. The elimination of the independent medical exams on extent of disability, for instance. Significant savings there." Tape Recording, Special Committee on Workers' Compensation, May 3, 1990, Tape 6, Side B at 270.

Senator Joyce Cohen, a member of the same committee, responded to a witness' concern about problems created by independent medical examination:

> "The independent medical exams have been essentially removed * * * at least in the same configuration that they are being used now." Tape Recording, Special Committee on **<125 Or App 669/670>** Workers' Compensation, May 4, 1993, Tape 11, Side A at 210.

Those references indicate that the legislature intended to eliminate Board reliance on independent medical examinations as a basis for its evaluation of a worker's disability. The objective of the statute was to save employers the cost of such examinations and to require the Board to consider only the attending physician's impairment findings in evaluating a disability. The Board's interpretation defeats that objective, because it invites employers to pay for independent medical examinations that might develop findings that employers could use to impeach the attending physician's findings. The legislature intended to eliminate the incentive to incur those costs.

We recognize the distinction between offering an independent medical examiner's impairment findings for impeachment, rather than as proof of employer's factual contention regarding the extent of impairment. However, the statute does not make that distinction. An independent medical examiner's impairment findings that the employer offers for impeachment are, nonetheless, findings regarding the worker's impairment that evaluate the disability. The legislature intended to permit only the attending physician to make such findings. The Board violated ORS 656.245(3)(b)(B) by receiving and considering the impairment findings of an independent medical examiner.

Because the Board relied on Nathan's impairment findings, we cannot say that the Board would have reached the same result despite that error. We remand for reconsideration of the record in compliance with ORS 656.245(3)(b)(B).

Reversed and remanded for reconsideration.

Cite as 125 Or App 684 (1994) January 5, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Darrell W. Vinson, Claimant.

SAIF CORPORATION and DEJONG PRODUCTS, INC., Petitioners,
v.
DARRELL W. **VINSON**, CRAWFORD & COMPANY and J & E KEISTER, Respondents.
WCB Nos. 91-05363, 91-08114, 91-08115, 91-04982; CA A78727)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 17, 1993.

David L. Runner, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Daniel J. DeNorch argued the cause and filed the brief for respondent Darrell M. Vinson.

Thomas M. Christ argued the cause and filed the brief for respondents Crawford & Company and J & E Keister.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

125 Or App 685> SAIF seeks review of an order of the Workers' Compensation Board holding that claimant had suffered a new compensable injury that shifted responsibility for his injury from his first employer, Crawford & Company, to SAIF's insured, DeJong Products. SAIF argues that the Board erred in failing to apply the major contributing cause standard of ORS 656.005(7)(a)(B) to the responsibility dispute under ORS 656.308(1).

Here, the Board found that claimant's accidental injury at SAIF's insured was a *material contributing cause* of his need for treatment and disability, and, on the basis of that finding, held that responsibility had shifted from the first employer to SAIF's insured. Under the Supreme Court's holding in *SAIF v. Drews*, 318 Or 1, 9, 860 P2d 254 (1993), the first employer remains responsible unless the claimant has suffered a new injury that is the *major contributing cause* of the need for treatment. ORS 656.005(7)(a)(B); ORS 656.308(1). We reverse the Board's order and remand for reconsideration in the light of *SAIF v. Drews, supra.*

Reversed and remanded for reconsideration.

Cite as 126 Or App 1 (1994) January 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

FRANK **KING**, dba King Feed Lot, ZENITH INSURANCE and CONTINENTAL LOSS ADJUSTING SERVICES, Petitioners,

v.

DEPARTMENT OF INSURANCE AND FINANCE, Respondent.

(WCB 90-18834; CA A72815)

Judicial Review from Department of Insurance and Finance.

Argued and submitted November 25, 1992.

Darren L. Otto argued the cause for petitioners. On the Brief were Bradley R. Scheminske and Scheminske & Lyons.

David L. Runner, Assistant Attorney General, argued the cause for respondent. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.

Before Richardson, Chief Judge, Deits, Judge, and Durham, Judge pro tempore.

RICHARDSON, C.J.

Affirmed.

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126 Or App 3> Employer seeks review of an order of the Director of the Department of Insurance and Finance (DIF)[1] that denied attorney fees to employer under ORS 656.740(5). We affirm the denial of attorney fees.

DIF issued a proposed order of noncompliance after an investigation [2] disclosed that no guaranty contract for workers' compensation insurance coverage had been filed. Employer requested a hearing and asserted that Zenith Insurance Company (Zenith) had provided coverage during the relevant period. At the hearing, Zenith conceded that it had provided coverage during the disputed period and agreed to issue a guaranty contract to that effect. The hearing was postponed. After the guaranty contract was issued by Zenith, DIF rescinded its proposed order of noncompliance and requested that the hearing be dismissed. Employer and Zenith requested that the referee set aside DIF's proposed order and award attorney fees to employer. The referee held that the proposed noncompliance order had been correct at the time that it was issued and affirmed the proposed order, "as since rescinded." The referee denied attorney fees under ORS 656.740(5).

The only issue on review is whether the referee erred in denying employer attorney fees.[3] Employer argues that, because the proposed order of noncompliance was rescinded as a direct result of its attorney's efforts, it is entitled to attorney fees under ORS 656.740(5), which provides that

> "[i]f a person against whom an order is issued pursuant to this section prevails at hearing or on appeal, the person is **<126 Or App 3/4>** entitled to reasonable attorney fees to be paid by the director from the Insurance and Finance Fund."

The issue is whether employer prevailed at the hearing. We have not had the occasion to construe ORS 656.740(5). In determining the legislative intent regarding the award of attorney fees, we first consider the text and context of the statute. *State ex rel Kirsch v. Curnutt*, 317 Or 92, 96, 853 P2d 1312 (1993).

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[1] The order of the referee of the Workers' Compensation Board is deemed to be the final order of the director of DIF. ORS 656.740(4)(a).

[2] The investigation was prompted by an injury claim that is not part of this petition for review.

[3] On review, employer also assigns as error the referee's determination that the proposed noncompliance order was correct. Employer makes this separate assignment because the referee's order purports to affirm the rescinded proposed order that held employer to be a noncomplying employer. The separate assignment is unnecessary. The referee did not have authority to reinstate the rescinded order. The only issue left to review is whether the referee erred in denying attorney fees. Consequently, we only address employer's argument regarding the correctness of the proposed order to the extent that it is pertinent to the determination of attorney fees.

ORS 656.740(5) requires that the party seeking attorney fees be a "person against whom an order is issued pursuant to this section." ORS 656.740(1) describes such an order as "a proposed order of the director declaring that person to be a noncomplying employer." That subsection also provides that the proposed order is "prima facie correct" and "the burden is upon the employer to prove that the order is incorrect." Reading the language of ORS 656.740(1) in conjunction with the language in ORS 656.740(5), the meaning of "prevails" is clear: An employer seeking attorney fees under ORS 656.740(5) prevails if it establishes, at hearing or on appeal, that the proposed order of noncompliance was incorrect.[4]

The proposed order held that employer was noncomplying because it did not meet the requirements of ORS 656.017 as either a carrier-insured employer or a self-insured employer. ORS 656.005(18) defines a noncomplying employer as "a subject employer who has failed to comply with ORS 656.017." Employer did not claim to qualify as a self-insured employer. ORS 656.407 explains how an employer "maintain[s] assurance" with DIF that it qualifies as a "carrier-insured" employer:

> "(1) An employer shall establish proof with the director that the employer is qualified * * *:
>
> "(a) As a carrier-insured employer by causing a guaranty contract issued by a guaranty contract insurer to be filed with the director * * *."

Under the statutory scheme, an employer is required to cause a guaranty contract to be filed with DIF to meet the **<126 Or App 4/5>** requirements of ORS 656.017(1). An employer that does not cause a guaranty contract to be filed has not complied with ORS 656.017 and therefore is a noncomplying employer under ORS 656.005(18).

It is undisputed that, at the time the proposed order was issued, employer had not caused a guaranty contract to be filed with DIF. As a result, employer was a noncomplying employer under ORS 656.005(18), and the proposed order was correct until the guaranty was filed with DIF. Once the guaranty was filed, employer became a complying employer and DIF rescinded its proposed order. DIF did not rescind the proposed order because it was incorrectly issued, but because employer finally complied with the law. Because employer did not establish that the proposed order was incorrect, the referee did not err in denying attorney fees under ORS 656.740(5).

Affirmed.

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[4] Because the text and context of ORS 656.740(5) is determinative of legislative intent, we need not consider legislative history or other aids of statutory construction. *State ex rel Kirsch v. Curnutt, supra.*

Cite as 126 Or App 6 (1994) January 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

MILWAUKIE CONVALESCENT AND RESIDENTIAL CARE CENTER, an Oregon corporation, Petitioner,

v.

NATIONAL COUNCIL ON COMPENSATION INSURANCE and SAIF CORPORATION, Respondents.

(90-02-032; CA A72121))

Judicial Review from Department of Insurance and Finance.

Argued and submitted October 21, 1992.

Donald L. Dickerson argued the cause and filed the brief for petitioner.

Peter A. Ozanne waived appearance for respondent National Council on Compensation Insurance.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.

Before Richardson, Chief Judge, Deits, Judge, and Durham, Judge pro tempore.

RICHARDSON, C.J.

Affirmed.

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126 Or App 8> Employer is an Oregon corporation that operates an adult nursing home facility. It seeks review of an order of the Department of Insurance and Finance (DIF) that upheld the results of a premium audit by its workers' compensation insurer, SAIF. We affirm.

SAIF conducted an audit of employer's payroll for the periods July, 1987, through June, 1988, and July, 1988, through June, 1989. SAIF assessed additional premiums on the basis of its determination that two persons hired as subcontractors were employees and not independent contractors. SAIF also concluded that some employees should be placed into a different job classification for premium calculation.

Employer operates a nursing home and most of its employees are engaged in that activity. However, during the periods in dispute, employer built an addition to its facility. It acted as the general contractor for the construction project and hired various subcontractors to do the construction work. Employer's secretary-treasurer, Eivers, who was also a full-time employee, acted as the supervisor of the construction. In its findings, DIF described Eiver's activities, in relation to the project:

> "In addition to his normal duties, during the construction Eivers also solicited bids from construction firms and selected those who would receive the various construction jobs. Eivers did not personally engage in any construction work. He visited the construction site daily, speaking with the architect and the workers. Eivers had copies of detailed plans that he received from the architect and would often discuss these plans with the architect, city inspectors, and the workers. Eivers assured that the workers were at the work site. He assured that the workers did what they were supposed to do. He assured that materials were delivered to the job site. He checked daily on the progress that the workers made toward completion of the job. Eivers ordered, and [employer] paid for lumber and roofing material that the workers indicated were needed for the project.
>
> "One of the firms performing framing construction for [employer] was Robinette. Robinette had employees working on [employer's] construction project. [Employer] did not **<126 Or App 8/9>** require proof of workers' compensation coverage from Robinette. Robinette had no workers' compensation insurance coverage for its employees. [Employer] did not check with the Builders' Board to determine whether Robinette was registered as a builder with the State of Oregon. [Employer] and Robinette had a written contract describing their relationship. That agreement indicates that [employer] is the 'Contractor' and Robinette is the 'Subcontractor'.
>
> "McKinley also worked on [employer's] construction site. [Employer] did not require proof of workers' compensation coverage for McKinley, nor did [employer]

> inquire whether McKinley maintained such coverage. McKinley had no such coverage. [Employer] did not check with the Builders' Board to determine whether McKinley was registered as a builder with the State of Oregon. McKinley was not so registered. [Employer] had no written contract with McKinley for his services."

DIF concluded that the two subcontractors were subject to employer's direction and control and that there was insufficient evidence to establish that they were independent contractors and not employees. Employer argues that there is no evidence that the two contractors were subject to its control and that the "nature of their work" is as independent contractors, as opposed to covered employees.

An employer who challenges DIF's orders made under ORS 737.505 has the burden of proving that premium determinations are wrong. *Salem Decorating v. Natl. Council on Comp. Ins.*, 116 Or App 166, 840 P2d 739 (1992), *rev den* 315 Or 643 (1993). Employer's argument is essentially that the evidence presented supports a conclusion that the two subcontractors were independent businesses. Employer, however, presented very little evidence about the nature of the two men's work or business and about the degree of control actually exercised by employers. The findings about control are supported by substantial evidence and there is a reasoned conclusion by DIF from the findings. We agree with DIF that employer did not meet its burden of establishing that the subcontractors were not covered employees.

Employer next argues that two of its employees in the nursing home operation were incorrectly reclassified to job classes with higher premiums. Employer contends that both of these employees should be classified as clerical office **<126 Or App 9/10>** workers rather than convalescent home workers, a higher premium class. To be placed in the lower rate classification, the employees must perform clerical duties while in areas physically separated from other operations of the nursing home. The payroll of clerical employees, who perform other functions allocated to the higher rate class, may be prorated to both classifications for premium calculations. However, OAR 836-42-060(2) requires that employer keep accurate, verifiable records of the employee's work and its location in the facility. If such records are not kept, the employee's entire payroll is allocated to the higher rate class.

DIF found that one administrative employee, who was classified as a clerical worker, actually performed non-clerical functions such as aiding patients, meeting with residents and their families and showing people around the facility. Because employer's records did not accurately allocate this employee's duties, his entire payroll was placed in the higher classification. DIF also found that a bookkeeper for employer performed billing, accounts receivable and accounts payable functions in the computer room. DIF determined that the computer room was not a separate area as required under the rules, and concluded that the bookkeeper's payroll therefore could not be classified as exclusively clerical.

Employer argues that the administrative employee performed mostly clerical duties and that any of the other things he did were incidental. However, there is evidence to support DIF's findings. If that employee in fact worked outside a separate physical space or did work in two classifications, employer did not provide verifiable records from which a proration of the payroll could be made. We agree with DIF that employer did not meet its burden to controvert DIF's findings.

Employer argues that the bookkeeper performed clerical functions exclusively. DIF, however, found that she was not physically separated from the other nursing home operations. Employer offered no evidence about the location of her work station or even about the physical location of the "computer room." Again, employer has not met its burden to establish that the classification was incorrect.

126 Or App 11> Employer argues that the payroll of several other employees should have been prorated to both clerical and nonclerical classifications for premium calculations. DIF found that employer's records did not adequately specify the type and location of work performed by those employees to prorate the payroll. Substantial evidence supports DIF's findings.

Employer finally argues that, even if it failed to keep appropriate records, SAIF is estopped from billing it for the higher premium because SAIF approved its payroll reporting procedures. Although DIF did not specifically analyze employer's estoppel argument, we interpret the order as rejecting the contention. Even viewing the evidence in the light most favorable to employer, there is no factual basis for applying equitable estoppel to prevent SAIF from billing at the higher premium rate.

Affirmed.

Cite as 126 Or App 69 (1994) January 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joyce E. Stoddard, Claimant.

GOOD SAMARITAN HOSPITAL, Petitioner,
v.
JOYCE E. **STODDARD**, ALBERTINA KERR CENTER, LIBERTY NORTHWEST INSURANCE CORPORATION and FRED MEYER, INC., Respondents.
(91-14419, 90-20316, 91-03626; CA A78338)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 14, 1993.
Eli D. Stutsman, argued the cause for petitioner. With him on the brief was Janet M. Schroer, Delbert J. Brenneman and Hoffman, Hart & Wagner.
Michael R. Dehner argued the cause for respondent Joyce E. Stoddard. With him on the brief were Daniel J. DeNorch, Merrill Schneider, and Schneider, DeNorch & Galvaviz-Stoller.
Bruce L. Byerly argued the cause for respondent Fred Meyer, Inc. With him on the brief was Moscato, Byerly & Skopil.
James D. McVittie waived appearance for respondents Albertina Kerr Center and Liberty Northwest Insurance Corporation.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
EDMONDS, J.
Reversed and remanded for entry of order denying claim.

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126 Or App 71> Employer, Good Samaritan Hospital, seeks review of a Workers' Compensation Board order that affirmed the referee's holding that claimant's wrist claim was not barred by a previous settlement claiming that the Board committed legal error.[1] We reverse.

These facts found by the referee and adopted by the Board are supported by substantial evidence. On January 6, 1990, while claimant was working for employer as a nurse's assistant, her right wrist was injured when a patient grabbed it and bent it backward. Claimant's physician, Dr. Brown, and her treating orthopedist, Dr. Cohen, diagnosed the injury as a wrist strain. Cohen noted that claimant had some pain in her right forearm after this injury. Claimant filed a claim, which employer accepted in March, 1990.[2] Claimant reinjured her wrist in April, 1990, while she was working as a clerk at Fred Meyer. Cohen diagnosed claimant's injury as a strain, and Fred Meyer accepted the claim.[3] In July, 1990, Cohen noted that claimant was continuing to have pain in her right forearm and scheduled her for diagnostic tests. On September 10, 1990, Cohen reported to employer that claimant had a probable radial nerve entrapment condition and on September 26, 1990, he requested authorization for surgery from employer's claim processor.

On September 26, 1990, employer and claimant entered into a stipulated settlement concerning the accepted wrist claim, which was approved by the Board on October 26, 1990. It provided, in part:

> "For purposes of ORS 656.273, the date this settlement document is approved by a referee shall constitute the last award or arrangement of compensation for the claimant on the January 6, 1990 accepted right wrist claim. *That claim* **<126 Or App 71/72>** *will remain in a closed status with all issues which were raised or which could have been raised on or before the date of this settlement is approved by a referee, having been resolved with prejudice.*" (Emphasis supplied.)

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[1] The Board's order also affirmed the referee's denial of penalties, award of attorney fees, and denials of the same condition issued by Albertina Kerr Center, Liberty Northwest Insurance Corporation and Fred Meyer, Inc. There are no assignments of error relating to those issues and the only parties on review are claimant and Good Samaritan Hospital.

[2] Claimant also filed a psychological stress claim, which employer denied. That claim is not at issue on review.

[3] Issues concerning the injury that occurred while claimant was working at Fred Meyer are not involved here.

Four days after the settlement was approved, claimant requested a hearing concerning her nerve condition, even though employer had not formally denied Cohen's request for authorization for surgery. In its response to claimant's request, employer contested the compensability of and its responsibility for the nerve condition. The referee concluded that the nerve condition was caused by claimant's January 6, 1990, injury, and assigned responsibility to employer. Employer contended that claimant was barred from asserting the nerve condition claim, because that claim was settled as part of the October 26, 1990 settlement. The referee rejected employer's argument and ordered it to accept the condition.

On review, the Board affirmed, stating:

> "Claimant waived her right to claim the compensability of her right radial nerve entrapment condition against [employer] only if she intended to waive that right when she signed the stipulation. Although her treating physician had diagnosed the condition and requested medical services at the time of the stipulation, [employer] had not yet stated its intention whether it would authorize the surgery or deny the September 1990 claim. Because the statutory scheme does not permit a hearing on the compensability of a claim prior to an acceptance or denial * * *, the compensability of her nerve entrapment condition against [employer] was not yet ripe and, thus, could not have been waived."

On review, employer says that the Board erred as a matter of law in construing the terms of the settlement and argues that claimant's nerve condition is encompassed by its terms, because it was an issue raised or raisable before the settlement was approved.

Neither party argues that the language of the settlement is ambiguous. When an agreement is unambiguous, its interpretation is as a matter of law, *Timberline Equip. v. St. Paul Fire and Mar. Ins.*, 281 Or 639, 643, 576 P2d 1244 (1978), and we must decide whether the Board made a legal error when it construed the agreement. We understand the Board's reasoning to be that a denial by employer was a legal **<126 Or App 72/73>** predicate before claimant could be held to have settled the claim for her nerve condition. We disagree. The correct inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement. *See Safeway Stores, Inc. v. Seney*, 124 Or App 450, 454, ___ P2d ___ (1993). The settlement expressly states that the January 6, 1990, accepted right wrist claim "will remain in a closed status with all issues which were raised or which could have been raised on or before the date of this settlement is approved by a referee, having been resolved with prejudice." The agreement settles all issues that relate to the January, 1990, injury that could have been raised before October 26, 1990. The Board found that claimant's nerve condition was related to the January, 1990, injury and that Cohen had diagnosed the condition and requested medical services at the time the settlement was signed by the parties. Based on those findings, claimant's nerve condition was an issue that could have been raised before October 26, 1990, and, therefore, her claim is barred by the settlement agreement.

Reversed and remanded for entry of order denying claim.

Cite as 126 Or App 108 (1994) January 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Mary E. Coleman, Claimant.

MARY E. **COLEMAN**, Petitioner,
v.
LAMB-WESTON, INC., Respondent.
(WCB 90-16879; CA A75971)

On remand from the Oregon Supreme Court, *Coleman v. Lamb-Weston, Inc.*, 318 Or 58, ___ P2d ___ (1993).
Judicial Review from Workers' Compensation Board.
Submitted on remand December 29, 1993.
Eileen G. Simpson argued the cause and filed the brief for petitioner.
Ronald W. Atwood argued the cause for respondent. With him on the brief was Teresa A. Statler.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Petition for judicial review dismissed.

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126 Or App 109> This workers' compensation case is on remand from the Supreme Court, *Coleman v. Lamb-Weston, Inc.*, 318 Or 58, ___ P2d ___ (1993), which held that claimant's petition for judicial review was not timely filed. We were without jurisdiction to consider the petition.

Petition for judicial review dismissed.

Cite as 126 Or App 110 (1994) January 19, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kurt D. Cutlip, Claimant.

CRAWFORD & COMPANY and EPSON PORTLAND, INC., Petitioners,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION, OREGON-CANADIAN FOREST PRODUCTS and KURT D. CUTLIP, Respondents.
(WCB 91-12437, 91-13835; CA A78445)

Judicial Review from Workers' Compensation Board.
On petitioners' motion for reconsideration filed November 8, 1993. Opinion filed October 20, 1993. 124 Or App 210, 859 P2d 1202.
William H. Walters, and Miller, Nash, Wiener, Hager & Carlsen for motion.
No appearance contra.
Before Deits, Presiding Judge, and Riggs, Judge, and Durham, Judge pro tempore.
PER CURIAM
Reconsideration allowed; opinion withdrawn; reversed and remanded for reconsideration.

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126 Or App 111> Petitioners move for reconsideration of our opinion, 124 Or App 210, 859 P2d 1202, affirming an order of the Workers' Compensation Board on the basis of our holding in *SAIF v. Drews*, 117 Or App 596, 845 P2d 215 (1993). *Drews* held that, in cases involving successive injuries, the employer with the last accepted claim need only prove that a new industrial injury involving the same condition materially contributed to claimant's condition, in order to shift responsibility to a subsequent employer under ORS 656.308(1). However, the Supreme Court subsequently reversed our decision in *Drews* and held that the employer with the last accepted claim must prove that the new injury at a subsequent employer is the major contributing cause of the need for treatment in order to shift responsibility to the later employer. *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993). In view of the Supreme Court's decision, we allow reconsideration, withdraw our opinion and reverse and remand to the Board for reconsideration under the proper standard.

Reconsideration allowed; opinion withdrawn; reversed and remanded for reconsideration.

Cite as 126 Or App 117 (1994) January 26, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jerome A. Young, Claimant.

ITT HARTFORD INSURANCE GROUP and FLEETWOOD OF OREGON, Petitioners,
v.
JEROME A. **YOUNG**; MILGARD MANUFACTURING, INC.; KEMPER INSURANCE COMPANY; and LUMBERMAN'S MUTUAL, Respondents.
(91-04933, 91-01167 and 92-01499; CA A79279)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed November 24, 1993. Decision filed November 10, 1993. 124 Or App 678, ___ P2d ____.

John D. Ostrander, Tooze Shenker Duden and Creamer Frank & Hutchison for the petition

Darrell E. Bewley and Estell & Bewley contra.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

ROSSMAN, P.J.

Reconsideration allowed; decision withdrawn; reversed and remanded for reconsideration.

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126 Or App 119> Relying on our opinion in *SAIF v. Drews*, 117 Or App 596, 845 P2d 217 (1993), which interpreted ORS 656.308, we affirmed without opinion the Workers' Compensation Board's order in this case holding that Milgard Manufacturing, Inc., had established that claimant's employment at Fleetwood of Oregon was a material contributing cause of his condition and that his condition was therefore the responsibility of Fleetwood. 124 Or App 678, ___ P2d ___ (1993). The Supreme Court reversed our decision in *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993), holding that, in order to shift responsibility to a subsequent employer under ORS 656.308, the last employer with an accepted claim has the burden to show that the subsequent employment is the major contributing cause of the condition. In the light of that reversal, Fleetwood seeks reconsideration of our decision. We allow reconsideration, withdraw our decision, and remand the case to the Board.

Here, the Board affirmed and adopted the referee's order, which said:

> "Although the standard is materiality, I will state that a major contributing cause standard *might lead to a different result*. Remembering that the initial employer has the burden of proof, I would find the evidence relatively evenly balanced concerning whether Milgard or Fleetwood were [*sic*] the major contributing cause of claimant's condition * * *." (Emphasis supplied.)

We remand this case to the Board for it to consider whether, under the major contributing cause standard, responsibility for claimant's compensable back condition shifts to Fleetwood.

Reconsideration allowed; decision withdrawn; reversed and remanded for reconsideration.

Cite as 126 Or App 120 (1994) January 26, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert Aagesen, Claimant.

ROBERT **AAGESEN**, Petitioner,
v.
SAIF CORPORATION, Respondent.
(TP-92011; CA A77727)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 8, 1993.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.
Michael O. Whitty, Assistant Attorney General, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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126 Or App 122> In this third-party distribution case, claimant seeks review of an order of the Workers' Compensation Board holding that SAIF is entitled to a share of the settlement in claimant's legal malpractice claim. We affirm the Board.

Claimant was compensably injured and received benefits from SAIF. He pursued a third-party action against a negligent third party and settled that action for $50,000, with SAIF's approval. SAIF received a portion of the settlement under ORS 656.593. Claimant then brought a legal malpractice claim against the attorney who had represented him in the third-party case. The Professional Liability Fund (PLF) settled that case for $75,000. SAIF sought further recovery out of the proceeds of that settlement. Claimant, the attorney who had been the defendant in the malpractice action and the PLF disputed SAIF's entitlement to a share of the proceeds. Because of that dispute, on October 23, 1990, the parties signed a "release and waiver of lien agreement" in which, in exchange for the $75,000 settlement amount, claimant agreed to release the PLF and the defendant-attorney from all claims. That document also stated:

> "SAIF Corporation and [claimant], by separate agreement, agree to hold a mutually satisfactory amount of the settlement funds under this agreement in trust until the funds are disbursed by court order or until such time as SAIF Corporation and [claimant] mutually agree to the disbursement of the funds from trust."

In fact, a letter from claimant's attorney to SAIF's counsel on October 15, 1990, shows that SAIF and claimant had already agreed that claimant's attorney would hold a portion of the settlement proceeds in trust "pending resolution with SAIF or a determination by the courts as to whether SAIF has a lien."

In July, 1991, we issued our decision in *Toole v. EBI Companies*, 108 Or App 57, 815 P2d 216 (1991), in which we held that a paying agency's lien does not extend to legal malpractice recovery. Immediately following our decision, claimant's counsel wrote a letter to SAIF's counsel:

> "You will recall that I have been holding the sum of $32,864.13 in trust from the settlement that [claimant] **<126 Or App 122/123>** made with the Professional Liability Fund, regarding a legal malpractice settlement involving the handling of the third-party case. The monies have been held pending the decision from the Court of Appeals as to whether or not a paying agency's lien attaches to the proceeds of a legal malpractice settlement.
>
> "In light of the court's decision in *Toole v. EBI Companies*, 108 Or App 87 (1991), [sic] please confirm that SAIF does not have a lien in this case and that I may disburse the monies that are being held in trust."

A petition for review was filed in *Toole*. We denied reconsideration of *Toole* on September 25, 1991. On October 29, 1991, SAIF's counsel wrote to claimant's counsel:

> "In the absence of Mr. Thurber, I have assumed the responsibility for the above matter.
>
> "Please advise of the status of the funds in your trust account dealing with the above claimant."

Claimant's counsel responded the next day:

> "Pursuant to the prior agreement with SAIF, the sum of $32,864.13 continues to be held in trust, along with accrued interest, pending outcome in *Toole v. EBI Companies*."

On December 17, 1991, the Supreme Court allowed review of our decision in *Toole*. 312 Or 527. On August 17, 1992, SAIF's counsel wrote to claimant's counsel:

> "Please accept my apology for not reviewing this file sooner. Unfortunately, somewhere in the transfer of the files to me I simply overlooked its existence.
>
> "The decision of *Toole v. EBI Companies*, 108 Or App 57 (1991) clearly establishes that SAIF has no lien against the proceeds of the settlement effected in the above matter.
>
> "You are authorized to disburse the sum of $32,864.13 held in your trust account in accordance with our previous correspondence.
>
> "I would appreciate written confirmation from you that disbursement has been made. I will then close our file."

On August 20, 1992, the Supreme Court issued its opinion in *Toole*, 314 Or 102, 838 P2d 60 (1992), reversing our decision and holding that the paying agency's lien *does* extend to legal malpractice recoveries. Apparently unaware of **<126 Or App 123/124>** that decision, claimant's counsel wrote a letter to SAIF on August 21, 1992:

> "Thank you for your letter of August 17, 1992, authorizing me to disburse the monies that I have been holding in trust ($32,864.13 plus accrued interest) to claimant, less attorney fees. Your letter states that SAIF concedes that it does not have a lien on these monies, and I am authorized to disburse the monies to Mr. Aagesen. I am hereby doing that. If I am incorrect in my reading of your letter, please let me know immediately."

On August 27, 1992, SAIF retracted its release of the trust funds, notifying claimant that SAIF's counsel had been misinformed of the status of *Toole*, and that the release had been issued in error.

The question on review is whether the Board erred in holding that, despite its release of the funds, SAIF may share in the proceeds of the PLF settlement. SAIF argues that the Board correctly held that it should not be held to its release of the funds, which it contends took place in error. Claimant contends that the release took place by the parties' "mutual agreement," as evidenced by SAIF's counsel's August 17, 1992, letter authorizing disbursement of those funds, and claimant's counsel's letter of August 21 acknowledging the release.

The Board found that a review of the relevant correspondence reveals that, initially, the parties intended that the funds would remain in the trust account "until such time as the funds are disbursed by court order or until such time as SAIF and [claimant] mutually agree to the disbursement of the funds from trust." It found further, that, after our opinion in *Toole*, the parties intended that the funds would remain in trust until *Toole* had been decided by the Supreme Court. That understanding is confirmed by claimant's counsel's letter to SAIF of October 30, 1991, in which he states that the funds continued to be held in trust "pending outcome in *Toole v. EBI Companies*."

In the light of the parties' intentions to await the outcome of *Toole*, the Board found that SAIF's release of the funds three days before the Supreme Court issued its decision in *Toole* was made on the mistaken belief that *Toole* was not under advisement in the Supreme Court. Additionally, it **<126 Or App 124/125>** found that the circumstances were such that claimant's counsel should have known of the mistake. *See Gardner v. Meiling*, 280 Or 665, 674, 572 P2d 1012 (1977); *Rushlight Co. v. City of Portland*, 189 Or 194, 219 P2d 732 (1950). Accordingly, it held that there was no "mutual agreement" for release of the funds, as claimant contends. The Board's findings are supported by substantial evidence, and the evidence supports the Board's conclusion. We affirm the Board's order permitting SAIF to withdraw its release and ordering a distribution of the settlement proceeds.

Affirmed.

Cite as 126 Or App 131 (1994) January 26, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Garry D. Smith, Claimant.

QUALIFIED CONTRACTORS, Petitioner,
v.
GARRY D. **SMITH**, Respondent.
(Agency No. 91-06313; CA A78830)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 22, 1993.
Margaret H. Leek Leiberan argued the cause for petitioner. With her on the brief were Lawrence E. Mann, Leiberan & Gazeley and Wallace & Klor.
Karen M. Werner argued the cause and filed the brief for respondent.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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126 Or App 133> The only issue in this workers' compensation case concerns the rate of time loss. The Board held that claimant is entitled to benefits for temporary total disability (TTD) calculated based on a seven-day work week and a 12-hour day. Employer contends that there is no substantial evidence to support the Board's decision. We affirm the Board.

The facts are not disputed. Claimant was hired by employer in February, 1989, as a journeyman boilermaker. He did not work continuously; employer would call him when work was available. If he was working on another job when he received a call from employer, he was not expected to quit that job and work for employer. When working on a job for employer, he would work regularly until the job was completed.

Claimant worked regularly for employer from February 27, 1989, through March 30, 1989; from April 3, 1989, through April 8, 1989; from May 18, 1989, through May 21, 1989; from June 26, 1989, through June 29, 1989; from July 11, 1989, through July 15, 1989; and from August 15, 1989, through August 17, 1989. He was injured on August 17. The job that he was on at that time was scheduled to continue for another week and a half. He had been working 12 hour days, seven days per week.

Under ORS 656.210(2), a worker who is regularly employed receives benefits calculated by multiplying the daily wage of the person by the number of days worked per week. Claimant contended before the Board that he was regularly employed, and that his wages should be calculated under the statute. The Board agreed that claimant had been regularly employed. It concluded, however, that because of the extended gaps in claimant's employment, OAR 436-60-020(7) was applicable, and that the parties' intentions would control concerning the calculation of claimant's benefits. The administrative rule 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 **<126 Or App 133/134>** employment to arrive at an average. *For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall also use the intent at the time of hire as confirmed by employer and the worker.*" (Emphasis supplied.)

The Board found, based on information provided by employer on the Form 801 and on claimant's testimony about his work schedule, that it was the parties' intention that when he was working claimant was employed 12 hours a day, seven days a week. The Board calculated claimant's weekly wage by multiplying his average daily wage by seven.

Employer agrees that the administrative rule is applicable and that the parties' intentions control. Employer argues, however, that substantial evidence does not support the Board's finding, because of the substantial gaps in claimant's employment. The Form 801 completed by employer at the time of the injury states that claimant worked 12-hour shifts, seven days a week. Claimant testified that, when he was working, he was expected to work 12-hour shifts, seven days a week. That evidence supports the Board's finding.

Affirmed.

Cite as 126 Or App 170 (1994) January 26, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jeanne S. Wall, Claimant.

JEANNE S. **WALL**, Petitioner,
v.
RAISING PRESCHOOL, INC., and SAIF CORPORATION, Respondents.
(91-01585; CA A76502)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1993.
Karen M. Werner argued the cause for petitioner. With her on the brief was Emmons, Kropp, Kryger, Alexander, Egan & Allen.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
PER CURIAM
Affirmed.

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126 Or App 171> Claimant seeks review of an order of the Workers' Compensation Board holding that it does not have jurisdiction to review an order of the Director under ORS 656.245(1)(b) concerning the appropriateness of palliative care. We have disposed of most of the issues that claimant raises in *Hathaway v. Health Future Enterprises*, 125 Or App 549, ___ P2d ___ (1993). Claimant contends that the Board's ruling that claimant has no right to a hearing on palliative care disputes violates the United States and Oregon constitutions. The issue is raised for the first time on review, and we will not address it.

Affirmed.

Cite as 126 Or App 172 (1994) January 26, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rexi L. Nicholson, Claimant.

REXI L. **NICHOLSON**, Petitioner,
v.
SALEM AREA TRANSIT and SAIF CORPORATION, Respondents.
(91-03460; CA A76237)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1993.
Karen M. Werner argued the cause for petitioner. With her on the brief was Emmons, Kropp, Kryger, Alexander, Egan & Allen.
Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
PER CURIAM
Affirmed.

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126 Or App 173> Claimant seeks review of an order of the Workers' Compensation Board holding that it does not have jurisdiction to review an order of the Director under ORS 656.245(1)(b) concerning the appropriateness of palliative care. We have disposed of most of the issues that claimant raises in *Hathaway v. Health Future Enterprises*, 125 Or App 549, ___ P2d ___ (1993). Claimant contends that the Board's ruling that claimant has no right to a hearing on palliative care disputes violates the United States and Oregon constitutions. The issue is raised for the first time on review, and we will not address it.

Affirmed.

Cite as 126 Or App 210 (1994) February 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jack W. Nethercott, Claimant.

JACK W. **NETHERCOTT**, Petitioner,
v.
SAIF CORPORATION and SEASIDE REALTY, Respondents.
(WCB No. 91-09935; CA A77382)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs May 26, 1993.
Jan H. Faber filed the brief for petitioner.
Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Julie K. Bolt, Special Assistant Attorney General, filed the brief for respondent.
Before Deits, Presiding Judge, and Riggs, Judge, and Durham, Judge pro tempore.
DEITS, P.J.
Affirmed.

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126 Or App 212> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of his claim for aggravation under ORS 656.273(1).[1] We review for substantial evidence, ORS 183.482(8)(c), and affirm.

Claimant injured his low back, left elbow and left shoulder in January, 1990. His claim was accepted by employer. On January 30, 1991, claimant's treating physician, Dr. Cockcroft, reported that he was medically stationary with "chronic back pain." However, claimant was restricted from lifting or pushing more than 30 pounds. The claim was closed on February 15, 1991, with an award of 13 percent unscheduled permanent partial disability. In June, 1991, Cockcroft again examined claimant and reported that he complained of increased lower back pain. Cockcroft noted that claimant was still restricted to light duty, i.e., lifting, pushing and pulling no more than 30 pounds, and that "he * * * *continued to remain disabled* and that * * * attempts at adjusting his leg lengths with shoe lifts, physical therapy and allowing time to heal, have been unsuccessful." (Emphasis supplied.) Claimant filed an aggravation claim. In August, 1991, Cockcroft reported that claimant's back pain "had waxed and waned over the 18 month period since his injury." Dr. Keizer, who had examined claimant before his accepted claim was closed, examined claimant in July, 1991. He later reported that claimant was "fit to return to some type of light work with restrictions" and that he "remained medically stationary."

Employer denied claimant's aggravation claim, and claimant appealed. The Board concluded that claimant had failed to establish his claim for aggravation under ORS **<126 Or App 212/213>** 656.273, because the medical evidence showed that his condition had not worsened. The Board said:

> "The medical evidence shows that since his January 1990 injury, claimant has experienced constant back pain. * * * The medical evidence, however, fails to prove that claimant's current symptoms are any greater than they were at the time of the February 1991 claim closure when claimant was awarded 13 percent unscheduled permanent disability."

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[1] ORS 656.273 provides:

"(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings.

"* * * * *

"(8) If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award."

An aggravation claim must be based on a "worsened condition" since the last award or arrangement of compensation. A worsened condition must be proved by medical evidence supported by objective findings. ORS 656.273(1). If the claimant has been awarded permanent disability for the underlying condition, the claimant must establish that the worsening is more than waxing and waning of symptoms contemplated by the award of disability. ORS 656.273(8). Worsening is a factual question. *Perry v. SAIF*, 307 Or 654, 657, 772 P2d 418 (1989).

Claimant argues that the Board's finding that his condition had not worsened is not supported by substantial evidence. We disagree. Claimant's treating physician and Keizer agreed that he remained medically stationary and is still capable of performing light duty. At the time that claimant's initial claim was closed, and he was awarded unscheduled permanent partial disability, there was medical evidence indicating that his low back pain was chronic. Claimant has had the same type of symptoms that he complains of now since before his claim was closed. The Board found that claimant failed to prove that his increased symptoms are more than the waxing and waning of symptoms contemplated by the award of disability and that finding is supported by substantial evidence. ORS 656.273(8). Although claimant testified that he is less able to function now than before his original claim was closed due to increased lower back pain, the medical evidence supports the Board's finding that his condition has not worsened. There is evidence that claimant's symptoms have not caused a loss of function of the body that resulted in loss of earning capacity beyond that for which claimant has already received an award of permanent partial disability. *See Perry v. SAIF, supra*, 307 Or at 657. The **<126 Or App 213/214>** Board's conclusion, that claimant did not prove an aggravation claim under ORS 656.273 because he had failed to prove a worsened condition, is supported by substantial evidence.

Affirmed.

Cite as 126 Or App 244 (1994) February 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gordon P. Kight, Claimant.

GEORGIA-PACIFIC CORPORATION, Petitioner,
v.
GORDON P. **KIGHT**, Respondent.
(91-09579; CA A79871)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 7, 1993.

Jerry K. Brown argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C.

James L. Edmunson argued the cause for respondent. On the brief were Edward J. Harri and Malagon, Moore, Johnson, Jensen & Correll.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

LANDAU, J.

Reversed and remanded for reconsideration.

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126 Or App 246> Employer seeks review of the Workers' Compensation Board's order holding that claimant's occupational disease claim is compensable. We reverse and remand.

Claimant filed an occupational disease claim, which employer denied on July 26, 1991. Claimant sought a hearing, and the case went to hearing on October 17, 1991. When the hearing was convened, claimant requested a continuance to depose his treating physician, Dr. Bert. Claimant represented to the referee that it was not possible to provide the witness live and that the deposition could not be scheduled on fewer than six weeks' notice. Employer objected to the continuance, arguing that claimant was not entitled to the continuance, because he had not shown due diligence. The referee found that the practice in the area is not to subpoena practitioners when a deposition may be taken, and that "it is not unusual" for six to eight weeks to be required to schedule a deposition. In the light of the fact that the hearing had been set rather quickly following the July 26 denial, the referee concluded that claimant had shown due diligence and was entitled to a continuance.

Claimant took the deposition of Bert, and it was accepted into evidence over employer's objections. The referee then concluded that claimant's total work exposure was the major contributing cause of his disability and need for treatment, and the Board affirmed, awarding attorney fees to claimant.

Employer raises several assignments of error, the first of which is that the Board erred in permitting the continuance and admitting evidence of the deposition of Bert. Because it is dispositive, we address only the first assignment.

We will reverse the Board's decision to grant claimant's request for a continuance if the Board acted outside the range of discretion delegated to it by law or if it acted inconsistently with its own rules, because those rules are as binding on the agency as if the legislature itself had enacted them. ORS 656.298(6); ORS 183.482(8)(b); *Bronson v. Moonen*, 270 Or 469, 476, 528 P2d 82 (1974); *Harsh Investment Corp. v. State Housing Division*, 88 Or App 151, 157, 744 P2d 588 (1987), *rev den* 305 Or 273 (1988).

126 Or App 247> OAR 438-06-091, the Board's rule governing continuances, provides:

> "The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. The referee may continue a hearing for further proceedings:
>
> "(1) If the time allocated for the scheduled hearing is insufficient to allow all parties to present their evidence and argument;
>
> "(2) Upon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence;
>
> "(3) Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing; or
>
> "(4) For any reason that would justify postponement of a scheduled hearing under 438-06-081.
>
> "The Referee shall state the specific reason for the continuance."

OAR 438-06-081, in turn, provides that hearings

> "shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement."

The same rule provides that "extraordinary circumstances" shall not include:

> "(2) Unavailability of a party, witness or representative due to * * * occupational, personal or professional or business appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person * * * is a person who has been duly subpoenaed and has failed to comply with the subpoena.
>
> "* * * * *
>
> "(4) Incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence."

Claimant argues that the continuance was properly granted under OAR 438-06-081(4), because the referee found **<126 Or App 247/248>** that completion of the record could not have been accomplished with due diligence. The rule, however, provides for postponement of the hearing only "upon a finding of extraordinary circumstances" beyond claimant's control. OAR 438-06-081. In this

case, the referee made no findings of "extraordinary circumstances" beyond claimant's control. The only finding is that Bert apparently was unavailable on less than six weeks' notice. The Board's rules expressly provide that the unavailability of a witness is not an "extraordinary circumstance," unless the witness has failed to appear after having been duly subpoenaed. Claimant concedes that he made no attempt to subpoena Bert. Under the circumstances, we conclude that the Board abused its discretion in affirming the referee's decision to grant a continuance without first making the findings that its rules require, and in admitting the deposition of Bert following the continuance.

Reversed and remanded for reconsideration.

Cite as 126 Or App 261 (1994) February 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Maria O. Samayoa, Claimant.

MARIA O. **SAMAYOA**, Petitioner,
v.
GREENWOOD INN and EBI COMPANIES, Respondents.
(WCB 91-04436; CA A76464)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 29, 1993.
Karen M. Werner argued the cause for petitioner. With her on the brief was Emmons, Kropp, Kryger, Alexander, Egan & Allen.
Nancy J. Meserow argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Affirmed.

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126 Or App 262> Claimant seeks review of an order of the Workers' Compensation Board holding that it does not have jurisdiction to review an order of the Director under ORS 656.245(1)(b) regarding the compensability of palliative care. We have decided most of the issues she raises contrary to her position in *Nicholson v. Salem Area Transit*, 125 Or App 549, ___ P2d ___ (1994), and *Hathaway v. Health Future Enterprises*, 125 Or App 549, ___ P2d ___ (1993). The constitutional issues that she raises were not raised below, and we will not address them for the first time on review.

Claimant also asserts that the care for which she seeks compensation is curative rather than palliative. So far as the record reveals, that argument was not raised until after the Director denied her claim for palliative care. Because the Board does not have jurisdiction to review the Director's order, we agree with the Board that it does not have jurisdiction to review any of the Director's findings, including its characterization of the medical treatment as palliative care.

Affirmed.

Cite as 126 Or App 343 (1994) February 16, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sandra J. Way, Claimant.

SANDRA J. **WAY**, Petitioner,
v.
FRED MEYER, INC., Respondent.
(WCB 91-13913; CA A79767)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 15, 1993.
Thomas A. Coleman argued the cause and filed the brief for petitioner.
Bruce L. Byerly argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P.J.
Affirmed.

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126 Or App 345> Claimant seeks review of an order in which the Workers' Compensation Board held that her claim for an occupational mental disorder is not compensable. We affirm.

Claimant seeks compensation for her anxiety disorder, which she asserts was caused by her employment. The Board found, and claimant does not challenge, that the disorder was caused in major part by reasonable disciplinary, corrective and performance evaluation actions by employer. Under ORS 656.802(3)(b), a mental disorder is not compensable "[u]nless the employment conditions producing the mental disorder are conditions other than * * * reasonable disciplinary, corrective or job performance evaluation actions by the employer * * *." Claimant asserts that the requirements of ORS 656.802(3)(b) are preempted by the Americans with Disabilities Act (ADA), 42 USC 12101 *et seq.* In particular, she argues that those requirements constitute discrimination by reason of her disability, which is prohibited by 42 USC 12132 and 28 CFR 35.130(b)(8).

42 USC 12132 provides:

> "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

The implementing regulations provide, in part:

> "A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered." 28 CFR 35.130(b)(8).

Claimant argues that requiring a claimant who has a mental disorder to prove that the disorder is not caused by the employer's reasonable disciplinary, corrective or job performance evaluation actions discriminates against persons with mental disorders, because claimants with other types of workers' compensation claims are not subject to the same requirement.

126 Or App 346> Whatever the merit of her discrimination argument, and we express no opinion about that or about whether the Board or this court is the appropriate forum to address the question, *see* 42 USC 12133; 28 CFR 35.170 - 35.190 (enforcement and compliance procedures), claimant cannot prevail. Title II of the ADA, which includes 42 USC 12132, became effective on January 26, 1992. Claimant filed her claim in August, 1991, before the ADA was in effect. She does not point to any language in the ADA that indicates a legislative intent to apply the Act to claims that arose before the effective date of the Act, and we find none. The only federal appellate court that has addressed the issue has concluded, in a *per curiam* opinion, that the ADA does not have retroactive effect. *See O'Bryant v. City of Midland*, 9 F3d 421 (5th Cir 1993). Therefore, the ADA does not apply to her claim.

The Board did not err in holding that the claim is not compensable.

Affirmed.

Cite as 126 Or App 450 (1994) February 23, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

EDWIN M. **ERRAND**, Appellant,

v.

CASCADE STEEL ROLLING MILLS, INC.,an Oregonn corporation, Respondent.

(CV91283; CA A80487)

Appeal from Circuit Court, Yamhill County.

John W. Hitchcock, Judge.

Argued and submitted December 20, 1993.

Sharon Stevens argued the cause for appellant. With her on the brief was Callahan and Stevens.

Ronald W. Atwood argued the cause for respondent. With him on the brief was Brad G. Garber.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

ROSSMAN, P.J.

Affirmed.

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126 Or App 452> Plaintiff worked at defendant's steel manufacturing plant. He has chronic infectious paranasal sinusitis, a pre-existing condition that predisposes him to experience airway irritation. During his employment with defendant, plaintiff suffered transient irritation of the upper respiratory tract and a bout of paranasal sinusitis as a result of inhalation of substances found in his work place. Plaintiff is a subject worker and defendant is in compliance with the Workers' Compensation Law, ORS chapter 656. Plaintiff sought medical treatment and filed a workers' compensation claim. Pursuant to ORS 656.802, the Workers' Compensation Board held that plaintiff was required to show that his employment was the major contributing cause of his condition or its worsening. The Board concluded that, although plaintiff's symptoms were caused by his employment, the symptoms were not the disease, and plaintiff's work exposure had not caused or worsened his chronic infectious paranasal sinusitis. Accordingly, it held that plaintiff had not established a compensable occupational disease.

Plaintiff did not seek judicial review of the Board's order. Instead, he filed this complaint against defendant in the circuit court, alleging statutory and negligence claims and seeking damages for economic losses, past and future medical bills, lost wages and impairment of earning capacity. The trial court granted defendant's motion for summary judgment, on the ground that plaintiff's exclusive remedy was under the Workers' Compensation Law and that defendant is immune from liability under ORS 656.018.

Plaintiff argues on review:

> "The rulings of the workers' compensation hearings referee and the Workers' Compensation Board that plaintiff's exposure to respiratory irritants at his work place is a noncompensable injury or condition mean that plaintiff's exposure and resulting injury and disability is [*sic*] not exclusively a workers' compensation matter. Plaintiff's recourse now lies outside of the workers' compensation law and issues of material fact were properly before the circuit court.
>
> "* * * * *
>
> "The workers' compensation laws concerning occupational exposures were designed to exclude certain types of **<126 Or App 452/453>** conditions or symptomatology from coverage under the workers' compensation law, even though certain conditions or symptoms are proven to be work-connected. ORS 656.802(2). This is the key in this case: *The condition suffered by the plaintiff and for which plaintiff seeks damages from the defendant is a condition not covered by the Workers' Compensation Act.*

"* * * * *

"Because plaintiff's airway irritation has been determined not to be covered by the workers' compensation statutes, and because the airway irritation is the result of inhalation of substances found in his work place, plaintiff has a direct action against defendant." (Emphasis plaintiff's.)

The gist of plaintiff's argument is that, because his condition does not entitle him to benefits under the Workers' Compensation Law, he may seek civil damages outside of the workers' compensation system.

ORS 656.018 provides, in part:

"(1) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers * * *.

"(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapterto bring suit against the employer of the worker for an injury." (Emphasis supplied.)

The statute expresses the dual nature of the exclusivity of the Workers' Compensation Law: the exclusivity of the employer's liability, ORS 656.018(1), and the exclusivity of the worker's rights. ORS 656.018(2). With certain exceptions not involved here, if the Workers' Compensation Act is applicable, and if the employer has satisfied its obligation to comply with the requirements of the Act, then the employer's liability to the worker for the worker's work-related injury or condition is exclusively under the Act, *and* the Act is also the exclusive remedy for the injured worker. That is one part of the *quid pro quo* that underlies our workers' compensation **<126 Or App 453/454>** system; the other part requires the employer to assume liability for work-related injuries without fault.

Focusing on the emphasized language of ORS 656.018, plaintiff asserts that its provisions for exclusivity do not apply, because he is not entitled to compensation for his condition:

"Since it has been ordered that plaintiff's case concerns a work-related exposure, but not an exposure recognized as a compensable workers' compensation claim covered by the workers' compensation law, plaintiff has a direct action for his alleged work-related disease or injury, and is not barred by the exclusivity provision of ORS 656.018 from maintaining this lawsuit."

We reject that reading of the statute. The exclusivity of the Act is not limited to claims that are ultimately determined to be compensable. As the Supreme Court said in *Reynolds et al v. Harbert et al*, 232 Or 586, 591, 275 P2d 245 (1962),

"the statutory scheme was intended to provide that a workman covered by Chapter 656 must accept the benefits thereof *as his exclusive remedy* * * *." (Emphasis supplied.)

Despite the changes to ORS chapter 656 since 1962, the policy behind the Supreme Court's decision in *Reynolds* remains the same. If the employer and the worker are subject to the Act, then the Act provides the worker's exclusive remedy for work-related injuries. If, under the Act, no compensation is available for the work-related injury, then the worker has no other remedy against the employer. Compare *Carr v. U S West Direct. Co.*, 98 Or App 30, 35, 779 P2d 154, *rev den* 308 Or 608 (1989) (no causal link shown between injury and risk connected with employment).

Plaintiff relies on *Hubbard v. Reynolds Metals Company*, 482 F2d 63 (9th Cir 1973), to support his view that a common law or statutory claim may lie for a condition that is not within the "coverage" of the Act. We would agree with that general proposition, although we would use different words to describe it. 2A Larson, *Workmen's Compensation Law* 12-1, 65 (1993). If, for example, the person is not a

subject worker, *see Metcalf v. Case*, 278 Or 629, 565 P2d 736 (1977), or if the injury or condition did not occur in the course **<126 Or App 454/455>** of employment, *see Sumnee v. Coe*, 40 Or App 815, 596 P2d 617 (1979), then the person's *claim* is not within the scope of the Act, and the Act cannot be the person's exclusive remedy. Plaintiff's claim is within the Act because he is a subject worker and his condition is alleged to have been caused by his employment.

A judicial remedy is not available for plaintiff's claim based on work-related exposures, because plaintiff's exclusive remedy is under the Workers' Compensation Act. The trial court did not err in granting defendant's motion for summary judgment.

Affirmed.

Cite as 126 Or App 541 (1994) February 23, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robin R. Oliver, Claimant.

ROBIN R. **OLIVER**, Petitioner,
v.
SCAMPS PET CENTER and SAIF CORPORATION, Respondents.
(91-07680; CA A77617)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed January 10, 1994. Opinion filed November 17, 1993. 124 Or App 663, 862 P2d 1327.

Kevin Keaney and Pozzi, Wilson, Atchison, O'Leary & Conboy for petition.

Before De Muniz, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judges.

PER CURIAM

Reconsideration allowed; opinion adhered to.

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126 Or App 542> Claimant petitions for review of our opinion. 124 Or App 663, 862 P2d 1327 (1993). We treat the petition as one for reconsideration. *Former* ORAP 9.15(1); ORAP 1.10. We grant the motion in order to address claimant's contention that our opinion is "fatally flawed," because we stated that the Board found that "the October claim was based on a new, separate exposure to psittacosis, and that that infection was not a continuation of the disease contracted in February." 124 Or App at 666. She contends that the Board did not make those findings.

Claimant is mistaken. Even if her contention was supported by the April, 1991, order she cites, that order is not before us on review. In *this* case, claimant petitioned for review of a November 6, 1992, Board order adopting the referee's December 27, 1991, order. The referee found that claimant was an irregular employee "at the time that *she had a new bout of psitticosis* [*sic*] in the fall of 1989," and that "[h]er condition in the fall of 1989 *was not a continuation of her EBI accepted condition*[.]" (Emphasis supplied.) Substantial evidence in the record supports those findings.

Reconsideration allowed; opinion adhered to.

Cite as 126 Or App 558 (1994) March 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James D. Terry, Claimant.

SAIF CORPORATION and HARRY & DAVID, INC., Petitioners,
v.
JAMES D. **TERRY**, Respondent.
(WCB No. 90-17722; CA A76704)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 21, 1993.
Steve Cotton, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.
Julie Zuver Ellickson argued the cause for respondent. On the brief were Jerome F. Bischoff and Bischoff & Strooband, P.C.
Before Deits, Presiding Judge, and Richardson, Chief Judge,* and Riggs, Judge.
DEITS, P.J.
Affirmed.
*Richardson, C.J., *vice* Durham, J.

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126 Or App 560> SAIF Corporation seeks review of a Workers' Compensation Board order awarding claimant permanent total disability benefits (PTD). ORS 656.206(1)(a). We affirm.

Claimant is a 58-year-old man who compensably injured his knee when he stepped off a ladder while working as a fruit picker. At the time of his injury, claimant was working eight hours per day, seven days per week, and was earning minimum wage. As a result of the injury, he has had numerous surgeries; the last one required the amputation of the lower portion of his leg. He now uses a wheelchair and is unable to wear a prothesis. He has a third grade education and a chronic learning disability. Since the time of his injury, he has received training in small appliance repair, but despite considerable effort he has been unable to find a job in that field. He is limited to light work.

Ten days before the hearing, after having submitted 104 job applications to potential employers, claimant started working at Burger King, as a broiler feeder. At the time of the hearing, he was working three hours per day, five days per week and was receiving minimum wage. However, the employer had modified the job of a broiler feeder to allow claimant to do the work. As the Board found:

> "His [claimant's] job description and site were both modified by the employer. The broiler-feeder normally feeds and removes the product from the broiler, which is actually a conveyor belt. [Claimant] wheels his chair onto a specially built platform and places the hamburgers, etc. on the conveyor for three hours per day - from 11:00 a.m. to 2:00 p.m. Someone else removes the product. The ramp is removed while [claimant] works; if he needs to use the restroom, another employer must reposition the ramp."

A worker is entitled to PTD benefits if the worker is able to prove that he or she is not able to perform work at a "gainful and suitable occupation." ORS 656.206(1)(a). As explained in *Tee v. Albertsons, Inc.*, 314 Or 633, 842 P2d 374 (1992), a "gainful occupation" is one that pays "profitable remuneration." SAIF argues that we should remand the Board order because the Board failed to make any determination regarding whether claimant's current employment is **<126 Or App 560/561>** "suitable" and because, in concluding that claimant's current employment was not regular "gainful employment," the Board did not address the question of whether claimant's current employment was for "profitable remuneration."[1]

SAIF is correct that in deciding that "claimant's current employment is not regular gainful employment," the Board did not directly address the question of whether claimant's job at Burger King

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[1] *Tee v. Albertsons, supra,* was not decided at the time of the Board's decision.

provided him with "profitable remuneration." It is unnecessary, however, to determine the effect of that failure. When it is asserted that a worker's current employment precludes the worker from being awarded PTD, the work must be *both* "gainful" and "suitable." ORS 656.206(1)(a). While it is correct that the Board did not use the term "suitable employment" in its conclusions, it did discuss the proper factors in determining suitability. We find that the Board's order supports its implicit conclusion that claimant's employment at Burger King was not "suitable" employment that would disqualify him from PTD.

A "suitable occupation" is defined as

> "[O]ne 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).

OAR 436-30-055(1)(b) provides:

> "'Suitable occupation' means those types of general occupations that exist in a theoretically normal labor market which is located within a reasonable geographic distance, being either full-time or part-time in duration * * *."

The Board concluded that "claimant is unable to sell his services on a regular basis in a competitive labor market." SAIF argues that this conclusion is wrong because claimant was successfully working as a broiler feeder at Burger King. However, in reaching the above conclusion, the Board considered claimant's present employment. It found that the broiler feeder job had to be modified to allow claimant to perform it. It also found that claimant's present employer "acknowledges that he is not getting his money's worth out of [claimant's] labors" and that "[h]e will probably retain **<126 Or App 561/562>** [claimant] after the six month wage subsidy program ends because [claimant's] work ethic is a good example to his younger employees." The Board concluded that "claimant's employment at the time of the hearing was 'reflective of [claimant's] pluck and the sympathy of the employer' and did not establish that claimant was competitively employable in a theoretically normal labor market." *See Harris v. SAIF*, 292 Or 683, 695, 642 P2d 1147 (1982); *Wiley v. SAIF*, 77 Or App 486, 490, 713 P2d 677, *rev den* 301 Or 77 (1986). We conclude that the Board did not err in awarding claimant PTD.

Affirmed.

Cite as 126 Or App 588 (1994) March 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel R. Jordison, Claimant.

DEAN T. **CATES**, dba Cates Construction, Petitioner,
v.
DANIEL R. **JORDISON** and SAIF CORPORATION, Respondents.
(91-12440; CA A77614)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 15, 1993.

Richard Wm. Davis argued the cause for petitioner. With him on the brief was Davis & Bostwick.

Karen Stolzberg argued the cause for respondent Daniel R. Jordison. With her on the brief was Goldberg & Mechanic.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs* and De Muniz, Judges.

RIGGS, J.

Affirmed.

*Riggs, J., *vice* Durham, J.

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126 Or App 590> Employer seeks review of an order of the Workers' Compensation Board that dismissed his request for a hearing on SAIF's acceptance of claimant's injury claim. He assigns error to

the conclusion that issue preclusion bars him from litigating the issue of compensability. We review for errors of law, ORS 656.298 and ORS 183.482(8), and affirm.

Claimant suffered an on-the-job injury in 1988. The Department of Insurance and Finance (DIF) issued a proposed order of noncompliance against employer for failing to carry workers' compensation coverage for claimant.[1] Employer requested a hearing and argued that claimant was not a subject worker. After a hearing, the Director of DIF (Director) issued a final order declaring claimant to be a subject worker and employer a noncomplying employer.

SAIF accepted the claim under ORS 656.054(1),[2] and employer requested a hearing. He argued that the claim was not compensable because claimant was not a subject worker at the time of his injury. The Board held that issue preclusion barred employer from arguing that claimant was not a subject worker and dismissed his request for a hearing, because he raised no other challenge to compensability.

Issue preclusion bars

> "future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139, 795 Or 531 (1990).

126 Or App 591> Employer argues that the Director's decision that claimant was a subject worker was not essential to the noncompliance decision because the opinion mentioned other subject workers for whom employer did not carry insurance. Although the opinion mentioned other workers, whether claimant is a subject worker was essential to the final decision. DIF's proposed order of noncompliance listed only claimant as the subject worker for whom employer should have provided coverage. Employer requested a hearing on that proposed order and presented evidence that claimant was not a subject worker. The Director's order provides:

> "The key issue in this case is whether [employer] was responsible, on September 9, 1988, for providing Workers' Compensation coverage for claimant. If he was responsible, claimant suffered a compensable injury on that date and [employer] is a noncomplying employer. If [employer] was not responsible, he is not a noncomplying employer and claimant did not suffer a compensable injury."

In its "Ultimate Findings of Fact," the order provides:

> "On [the date of the injury] claimant was working as an employee for [employer] and suffered an on-the-job injury."

Regardless of whether the Director could have arrived at the same result by finding other workers subject to coverage, it did arrive at the result by finding claimant to be a subject worker after employer had a full opportunity to litigate that issue. The issue of whether claimant was a subject worker was actually litigated at the compliance hearing and was necessary to the final decision of noncompliance.

Affirmed.

---

[1] ORS 656.052 provides, in part:

"(1) No person shall engage as a subject employer unless and until the person has provided coverage * * * for subject workers the person employs.

"(2) Whenever the director has reason to believe that any person has violated subsection (1) of this section, the director shall serve upon the person a proposed order declaring the person to be a noncomplying employer * * *."

[2] ORS 656.054(1) provides, in part:

"A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation * * *."

Cite as 126 Or App 633 (1994) March 2, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James W. Nicholls, Claimant.

ITT HARTFORD INSURANCE GROUP and COTTER AND COMPANY, Petitioners,
v.
JAMES W. **NICHOLLS**, Respondent.
(WCB 91-01349; CA A77429)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 18, 1993.
Stephen R. Frank argued the cause for petitioners. With him on the brief were Alison K. Greene and Tooze Shenker Duden Creamer Frank Hutchison.
Michael Dehner argued the cause for respondent. On the brief were Daniel J. DeNorch and Schneider, DeNorch & Galaviz-Stoller.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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126 Or App 634> Employer seeks review of an order of the Workers' Compensation Board holding that the Board did not have jurisdiction to determine whether chiropractic care that claimant had received was approved by claimant's attending physician and whether the treatment was palliative or curative.[1]

We recently held that a dispute over whether medical treatment that has already been received is palliative or curative is a matter covered by ORS 656.327(1), which, under *Meyers v. Darigold*, Inc., 123 Or App 217, 861 P2d 352 (1993), the Board may resolve as long as no party has sought review by the director of the Department of Insurance and Finance. *Theodore v. Safeway Stores*, Inc., 125 Or App 172, 861 P2d 352 (1993). We conclude that a dispute over whether the treatment that has already been provided was approved by the claimant's attending physician is similarly within the purview of ORS 656.327(1). Because no party has sought review by the director, the Board has jurisdiction to resolve both disputes. We remand for the Board to exercise its jurisdiction.

Reversed and remanded for reconsideration.

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[1] Employer's initial denial was based on ORS 656.245(3)(b)(A), which requires that, when certain services are provided by other than an attending physician, there must be written authorization by the claimant's attending physician. Employer asserted that the physician who authorized claimant's treatments was not claimant's attending physician. Employer then supplemented its denial, asserting that the chiropractic care was palliative and therefore not compensable under ORS 656.245(1)(b).

Cite as 126 Or App 658 (1994) March 9, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael M. Taylor, Claimant.

SAIF CORPORATION and ERICKSON & SON CONSTRUCTION, INC., Petitioners,
v.
MICHAEL M. **TAYLOR**, Respondent.
(Agency No. 92-03396; CA A79368)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 14, 1994.
Michael O. Whitty, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
John Hoadley argued the cause for respondent. On the brief was Gerald C. Doblie.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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126 Or App 660> Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in concluding that claimant was entitled to benefits for temporary total disability for the period during which he had no treating physician.

There is no dispute as to the facts. Claimant suffered a disabling lumbar strain on June 5, 1991, while working for employer. Employer initially denied the claim, but later accepted it by stipulation. The Board found that claimant was disabled from July 30, 1991, to November 1, 1991. SAIF does not challenge that finding. It contends, however, that for that period during which he had no attending physician and no attending physician authorized time loss, claimant is not entitled to benefits.

ORS 656.262(4)(b) provides that

> "[t]emporary disability compensation is not due and payable for any period of time for which the insurer * * * has requested from the worker's attending physician verification of the worker's inability to work * * * 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."

OAR 436-30-036(1) provides that

> "a worker is entitled to an award of temporary disability for all periods of time during an open claim in which the attending physician or authorized medical service provider * * * has authorized temporary disability."

The Board held that both the statute and the administrative rule pertain only to the worker's procedural entitlement to temporary disability, and have no bearing on the substantive right to benefits, which is established by a preponderance of the evidence showing that the claimant was disabled due to the compensable injury. In other words, the Board reasoned that, although the insurer's obligation to make payment of benefits for temporary disability *on an open claim* does not begin without the attending physician's verification of an inability to work, when it is determined upon claim closure that the claimant was disabled during the time when the claim was open, the claimant's substantive right to benefits **<126 Or App 660/661>** for temporary disability accrues, and the claimant is entitled to benefits for the entire period of disability. We agree with that reasoning. As we held in *Sandoval v. Crystal Pine*, 118 Or App 640, 848 P2d 1224, *rev den* 317 Or 272 (1993), the suspension of benefits pursuant to ORS 656.262(4)(b) due to the absence of medical verification of an inability to work does not terminate the claimant's substantive entitlement to benefits. The benefits to which the claimant is substantively entitled become due and payable when the claim is closed. Compare *Silsby v. SAIF*, 39 Or App 555, 561, 592 P2d 1074 (1979).

Affirmed.

Cite as 126 Or App 662 (1994) March 9, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kurt E. Hansen, Claimant.

SAIF CORPORATION and HANSEN FLOOR COVERING, INC., Petitioners,
v.
KURT E. **HANSEN**, Respondent.
(Agency No. 92-02086; CA A80326)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 7, 1994.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioners. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
David Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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126 Or App 664> SAIF seeks review of an order of the Workers' Compensation Board holding that SAIF is barred from denying claimant's claim on the ground that claimant was not a subject worker at the time of his injury.

The facts are not in dispute. In 1987, claimant was part owner, director and president of Hansen Floor Covering. The law did not require that he be covered by workers' compensation insurance, and he did not elect coverage under ORS 656.039. In March, 1987, claimant injured his knee on the job, and filed a claim with SAIF. SAIF's records show that, in April, 1987, SAIF had concluded that claimant was an "interested person without personal election coverage." Nonetheless, in May, 1987, SAIF accepted the claim, and it was closed with an award of benefits.

In late 1990, claimant began to develop symptoms of his knee condition again. SAIF denied an aggravation claim for treatment of the condition, on the ground that the condition was not related to claimant's 1987 injury. The matter went to hearing, and a referee determined that the condition was compensable and ordered that SAIF's denial be set aside. SAIF appealed the referee's order to the Board, but later withdrew its appeal, and the referee's order became final.

In January, 1992, SAIF issued the denial at issue here, for the first time contending that claimant was not eligible for benefits because, at the time of the injury, he was not a subject worker and had not elected coverage. Relying on *Camlu Retirement Center v. Evenhus*, 102 Or App 603, 795 P2d 606 (1990), and *Oak Crest Care Center v. Bond*, 101 Or App 15, 789 P2d 6, *rev den* 310 Or 121 (1990), the referee held that SAIF could deny the claim at any time for a lack of coverage. The Board reversed the referee, holding that employer was barred from denying the claim retroactively when the effect would be to leave the claimant without benefits. *Garcia v. SAIF*, 108 Or App 653, 816 P2d 1188 (1991).

We affirm the Board's order setting aside the denial. SAIF, having fully litigated the compensability of the claim, is barred by claim preclusion from denying it for lack of coverage. Claim preclusion bars the litigation of a claim based on **<126 Or App 664/665>** the "same factual transaction" that was or could have been litigated between the parties in a prior proceeding. It does not require actual litigation of an issue; nor does it require that the determination of the issue be essential to the final or end result reached in the proceeding. Only the opportunity to litigate is required. *Drews v. EBI Companies*, 310 Or 134, 795 P2d 531 (1990). As the Supreme Court said in *Drews*,

> "[w]here there is an opportunity to litigate the question along the road to the final determination of the action or proceeding, neither party may later litigate the subject or question." 310 Or at 140.

The only former adjudication between SAIF and claimant concerned the aggravation claim. SAIF argues that claim preclusion does not apply, because the facts involved in the denial of coverage are not the same as those at issue in the aggravation litigation. SAIF's understanding of the phrase "same factual transaction" is too narrow. In *Drews*, the Supreme Court said:

> "To prevent splitting of the dispute or controversy courts employ a broad definition of what could have been litigated. Claim preclusion conclusiveness between the parties applies 'with respect to all or any part of the transaction, or series of connected transactions,' out of which the action or proceeding arose." 310 Or at 141 (quoting *Restatement (Second) of Judgments* 24(1)).

SAIF's coverage of claimant's claim is inseparable from SAIF's obligation to pay compensation. In processing the claim, SAIF must necessarily have determined whether claimant was a person entitled to compensation. SAIF had the opportunity to litigate that question at the time it contested the compensability of the aggravation claim, but chose not to do so. Accordingly, we conclude that it may not litigate the question of coverage now.

Affirmed.

Cite as 126 Or App 666 (1994) March 9, 1994

IN THE COURT OF APPEALS OF THE STATE OF OREGON

GLENN **TERRIS**, Appellant,
v.
KENNETH **STODD**, Respondent.
(92-2106; CA A80272)

Appeal from Circuit Court, Columbia County.
Donald L. Kalberer, Judge.
Argued and submitted January 7, 1994.
Hank McCurdy argued the cause for appellant. With him on the briefs was Dobbins & McCurdy.
Joe D. Bailey argued the cause for respondent. With him on the brief was Wood Tatum Wonacott & Landis.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Reversed and remanded.

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126 Or App 668> Plaintiff appeals from a judgment for defendant in this legal malpractice action, assigning error to the trial court's granting of defendant's motion for summary judgment.

Plaintiff filed a workers' compensation claim against his employer, seeking benefits for a psychological condition allegedly caused by work-related stress. He entered into a disputed claim settlement (DCS) with the employer, in which he accepted $3,500 in full settlement of "all issues raised or raisable."

Plaintiff later consulted defendant, seeking advice as to whether he might have a tort claim against Mato Letica, an employee and officer of the employer. Plaintiff alleges in this action that defendant was negligent in allowing the statute of limitations to run on a third-party action against Letica. Defendant concedes that plaintiff may have been entitled to pursue a claim against Letica for assault and battery, *see* ORS 656.154(2), but argues, and the trial court held, that any such claim would have been barred by the DCS.

The record on summary judgment, viewed in the light most favorable to plaintiff, shows these facts: Plaintiff was employed by the employer as a plant manager when Letica, a corporate executive, came to visit the plant and, in the course of the visit, poked, punched, pulled, hit, pushed and grabbed

plaintiff, and threw him up against a wall and screamed at him, shouting obscenities. In December, 1989, the employer fired plaintiff. At about that same time, plaintiff filed his workers' compensation claim seeking benefits for disability and treatment related to stress. The DCS provides, in part, that

> "[b]oth parties have substantial evidence to support their contentions and each desires to settle all issues raised or raisable at this time by entering into a disputed claim settlement under the provisions of ORS 656.289(4) for the total sum of $3,500, to be paid to claimant by SAIF Corporation in lieu of any and all compensation claimed by claimant * * *.
>
> "* * * * *
>
> "Claimant shall have *no further right to compensation or any other legal right related to this claim.*" (Emphasis supplied.)

126 Or App 669> As an employee and officer of the employer, Letica is immune from tort liability pursuant to ORS 656.018(3), except if plaintiff's injury was caused by Letica's "willful and otherwise unprovoked aggression." ORS 656.018(3)(a). We have held that a person may seek damages in tort for intentionally caused injuries for which the plaintiff could have or did obtain compensation. *See Palmer v. Bi-Mart Company*, 92 Or App 470, 758 P2d 888 (1988). Plaintiff's assault and battery comes within the description of "willful and otherwise unprovoked aggression," and is not barred by ORS 656.018.

The trial court granted summary judgment to defendant on the ground that the DCS barred any tort claim plaintiff may have had against Letica. On its face, the DCS relates to *the claim for compensation* and to *all legal rights related to the claim.* We conclude that the DSC has no effect on a tort action that plaintiff might have had against Letica by virtue of the intentional nature of Letica's conduct. Although the injuries for which plaintiff may wish to recover damages in tort may have arisen from the same circumstances that gave rise to the claim for compensation, plaintiff's tort action is separate from the compensation claim and is outside the workers' compensation system. We hold that it is not barred by the DCS. The trial court erred in granting defendant's motion for summary judgment.

Reversed and remanded.

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