VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 39

(Pages 1013-END)

A compilation of the decisions of the Oregon Workers' Compensation Board and the opinions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law, and including Board administrative rules, adopted December, 1987

OCTOBER-DECEMBER 1987

Edited & published by:

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39 Van Natta ____ (1987)

WILLIAM F. CROSSLEY, Claimant
Malagon & Moore, Claimant's Attorneys
Cummins, et al., Defense Attorneys

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October 2, 1987
Own Motion Determination on
Second Reconsideration

Claimant has requested reconsideration of a portion of our September 11, 1987 Own Motion Determination on Reconsideration. Pursuant to our order, claimant was allowed an attorney fee equal to 25 percent of the 15 percent unscheduled permanent disability awarded by our order, not to exceed $350. Claimant questions the amount of the attorney fee.

If a proceeding is initiated under the Board's own motion jurisdiction because of a request from a claimant and an increase in compensation is awarded, the Board shall approve for claimant's attorney a reasonable fee payable out of any increase awarded by the Board. OAR 438-47-070(2). The amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained. OAR 438-47-010(2).

The aforementioned rules were fully considered in determining claimant's attorney fee award. After further review, we continue to find that, considering the "efforts expended" and the "results obtained," a $350 attorney fee award is reasonable.

Accordingly, the request for reconsideration is granted. On reconsideration we adhere to and republish our former order, as supplemented herein, effective this date.

IT IS SO ORDERED.

LARRY D. GROOMES, Claimant
Brian R. Whitehead, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Kevin L. Mannix, Defense Attorney

WCB 86-04011 & 86-05991
October 2, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The Argonaut Insurance Company requests review of Referee Danner's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld EBI Companies' denial of his "new injury" claim for the same condition. The issue is responsibility.

The Board affirms that portion of the Referee's order that found Argonaut responsible for claimant's condition.

The Board modifies that portion of the Referee's order that awarded an insurer-paid attorney fee for services rendered by claimant's attorney in procuring an order designating a paying agent under ORS 656.307.

Attorney fees awarded for services rendered prior to the issuance of a .307 order are payable out of, not in addition to, a claimant's award of compensation. ORS 656.386(1) and (2); Mark L. Queener, 38 Van Natta 882 (1986). Thus, the Referee's attorney fee is modified to reflect an award of 25 percent of claimant's compensation, not to exceed $900.

ORDER

The Referee's order dated January 12, 1987 is affirmed in part and modified in part. In lieu of the Referee's award of a $900 insurer-paid attorney fee, claimant's attorney is awarded 25 percent of claimant's compensation, not to exceed $900, for services rendered prior to the hearing in procuring an order designating a paying agent under ORS 656.307. The remainder of the Referee's order is affirmed.

DAVID J. PARDUN, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 86-09408
October 2, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Myers' order that awarded interim compensation from February 24, 1986 until the insurer's July 3, 1986 denial and assessed a related penalty and attorney fee. The issues are interim compensation, penalties and attorney fees.

Claimant has received a permanent disability award, stemming from a low back injury with a previous employer. In February 1986 claimant sought work from the present employer, King. Claimant told King of his previous back injury and stated that he would like the opportunity to see if he could still work in the woods. King was concerned about the possibility of a workers' compensation claim, but was assured that claimant already had an accepted claim with the SAIF Corporation and would not file a claim against him. King hired claimant.

While working in the woods, claimant did not experience any specific incidents of trauma to his back. However, after about five days, claimant's back condition prevented him from continuing the work. Claimant spoke to King about his inability to work in the woods. Regarding the conversation, King stated that claimant told him that he was having the same problems with his back as before and that he would not be able to perform that type of work. King also recalled that claimant told him that he had found out what he wanted about his ability to work in the woods. King denies that there was any conversation about filing claim forms or an injury. Claimant thanked him for the opportunity to work for him.

Claimant's version of the conversation is basically the same. However, claimant also testified that he informed King that his back was "messed up." Claimant acknowledges that he did not attempt to file a claim, but asserts that he asked King about any forms or paper work that needed to be filled out. He states that King told him that SAIF would be responsible. Claimant's employment terminated following this conversation on February 24, 1986.

Subsequently, claimant retained an attorney and filed an aggravation claim with SAIF. Sometime in May 1986, claimant phoned King and informed him that he needed to file a claim in order to protect all of his rights under the SAIF claim. King told claimant that he did not need to file a claim against him and that he would write a letter to SAIF explaining the situation if claimant would provide him with a stamped, addressed envelope.

Claimant never provided King with the envelope. In mid-May 1986 claimant returned to another type of work with a different employer. Claimant filed a claim with King on June 18, 1986. The insurer denied the claim on July 3, 1986. No interim compensation was paid.

The Referee concluded that claimant's February 24, 1986 conversation with King constituted sufficient knowledge of a claim that the employer had an obligation to begin payment of interim compensation. We disagree and modify the order of the Referee.

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(7). Further, "before a claim can exist, a worker must have asserted a right to workers' compensation benefits or an existing and potentially work-related injury or disease must have come to the attention of the employer." Donna J. Halsey, 39 Van Natta 118 (1987).

Both claimant and King were aware that claimant's previous back injury might preclude him from working in the woods. After five days, the possibility of his being restricted from working in the woods became real. Yet, claimant suffered no new incident of trauma nor told King that his back was worse. During the February 24, 1986 conversation, claimant did not assert a right to workers' compensation benefits. Further, we are not persuaded that claimant's physical inability to perform work in the woods was sufficient to put the employer on notice of a potentially work related injury or disease. We find that the employer did not have an obligation to pay interim compensation following his February 24, 1986 conversation with claimant.

However, claimant's phone call in May 1986 did inform the employer of a potentially work related injury. The exact date of the phone call was not determined at hearing. Claimant testified that he made the phone call after a myelogram. Dr. Tearce refers to the results of that myelogram on May 13, 1986.Consequently, we find that claimant made a claim with King on May 13, 1986. The insurer must begin the payment of interim compensation 14 days after the employer has knowledge of a claim. ORS 656.262(4). The insurer did not issue a denial until July 3, 1986. Consequently, the employer was obligated to pay interim compensation, less time worked, from May 13, 1986 until the July 3, 1986 denial.

The insurer provided no explanation for its failure to pay interim compensation following the 14th day it had notice of a claim. We agree with the Referee that claimant is entitled to a penalty and attorney fee for prevailing on this issue.

ORDER

The Referee's order dated December 15, 1986 is modified. In lieu of the Referee's award of interim compensation, claimant is entitled to interim compensation, less time worked, from May 13, 1986 until the July 3, 1986 denial. In lieu of the Referee's penalty assessment, the insurer is assessed a penalty equal to 5 percent of the aforementioned compensation. The remainder of the order is affirmed.

PAUL E. DANIELSON, Claimant
Michael B. Dye, Claimant's Attorney
Edward C. Olson, Defense Attorney
Cliff, Snarskis & Yager, Defense Attorneys

WCB 86-09787 & 85-05699
October 7, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated August 10, 1987 that did not award an attorney fee in a case involving the issue of responsibility. On August 28, 1987, we abated our order to allow sufficient time to consider claimant's request and Industrial Indemnity's response.

The issue of responsibility for claimant's low back condition had proceeded to hearing under an order designating a paying agent pursuant to ORS 656.307. We affirmed the Referee's order that had set aside Industrial Indemnity's denial of claimant's aggravation claim and had upheld North Pacific Insurance Company's denial of claimant's "new injury" claim. No attorney fee was awarded for claimant's attorney's services on Board review.

Claimant asserts entitlement to an attorney fee. He argues that he has consistently taken the position, at the Hearings level and on Board review, that Industrial Indemnity is responsible for his condition. Furthermore, he contends that his participation was "meaningful," since his employment for North Pacific's insured was on an "as needed" basis, while his employment with Industrial Indemnity's insured was full-time. In conclusion, he submits that the "resulting difference in time loss benefits might, therefore, be significant."

In support of his contention, claimant relies on SAIF v. Phipps, 85 Or App 436, 439 (1987). Phipps concerned a proceeding to determine responsibility between two insurers. A ".307 order" had been issued prior to the hearing. Stanley C. Phipps, 38 Van Natta 13, 16 (1986). Claimant's attorney participated at the hearing and also filed a brief before the Board, arguing that he had suffered an aggravation, rather than a new injury. The Board reversed the Referee's finding that claimant had sustained a new injury. However, determining that claimant was only a nominal party, the Board declined to award him an attorney fee at the hearing or on Board review. The Board relied on Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985), rev den 300 Or 722 (1986), which stated that "unless the claimant takes a position concerning which of the insurers is responsible and actively litigates that point," an award of attorney fees would generally be inappropriate. The court reversed, noting that claimant's stake in the outcome of the responsibility determination amounted to $120 more per week if his claim was processed as an aggravation. Since claimant had taken a position concerning which of the insurers was responsible and had actively litigated that point, the court concluded that he was entitled to an attorney fee under ORS 656.386.

We find the present case distinguishable. Here, as in Phipps, claimant has consistently advocated a position concerning responsibility for his condition. However, unlike Phipps, he did not "finally prevail" before the Board from an order or decision denying his claim for compensation. See ORS 656.386(1). Rather, his position prevailed before the Referee, for which he has previously been awarded an attorney fee. See OAR 438-47-090. Consequently, ORS 656.386(1) does not apply to this situation.

Moreover, in Phipps, the record established that claimant's compensation would be greater if his claim was processed as an aggravation. Here, at best, the record is speculative. Claimant as much as concedes this point by stating that "[t]he resulting difference in time loss benefits might, therefore, be significant." (Emphasis added).

If his claim was processed as an aggravation, claimant's temporary disability benefits would be based on full-time, rather than "on call" employment. Yet, the record is silent regarding his actual or average weekly earnings during his "on call" employment for the "new injury" employer. Thus, the evidence fails to establish the rate of claimant's compensation if his claim was processed as a "new injury." See OAR 436-60-020(4). Furthermore, claimant's hourly wage for his "new injury" employer was actually larger ($7.50) than his hourly wage for his "aggravation" employer ($7.25). Under these circumstances, we are unable to conclude that claimant had a greater stake in the outcome of the responsibility determination if his claim was determined to be an aggravation.

Based on the foregoing reasoning, we find that claimant's participation on Board review was not required to "protect his right to compensation." See Petshow v. Farm Bureau Ins. Co., 76 Or App at page 570. Therefore, we conclude that he is not entitled to an attorney fee for services on Board review. See ORS 656.382(2); Compare Robert L. Montgomery, 39 Van Natta 469 (1987) (Where no ".307 order" has been issued, attorney fee award on Board review is appropriate when claimant successfully defends a Referee's responsibility finding).

Accordingly, claimant's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

GREG HARTMAN, Claimant
Malagon & Moore, Claimant's Attorneys
Gary C. Jones, Defense Attorney

WCB 86-10525
October 7, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated August 14, 1987, which affirmed the Referee's finding that claimant's myocardial infarction claim was compensable. On September 3, 1987, we abated our order to consider claimant's request and the insurer's response.

In his request for reconsideration, claimant argues that he should receive an attorney fee "in excess" of the $650 fee awarded in our prior order. In support of his request, claimant's attorney points out that: (1) his brief consisted of 14 pages; (2) there were 80 exhibits; (3) the transcript consisted of 450 pages; and (4) the case presented a complex issue.

In awarding attorney fees for services on Board review, we generally look to the efforts of the attorney and the results obtained. OAR 438-07-010(2); Barbara Wheeler, 37 Van Natta 122 (1985). Here, claimant's attorney successfully defended the compensability of claimant's myocardial infarction claim on Board review. Furthermore, as stated in our prior order, we were

assisted by the parties well written briefs in resolving a "very close question."

Upon further consideration, we find that claimant's attorney fee on Board review should be modified. Considering the aforementioned points and authorities, we conclude that $800 is a reasonable attorney fee.

Accordingly, our prior order is modified insofar as the attorney fee awarded for services on Board review is increased to a total award of $800. Except as modified herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

RICHARD J. LECHER, Claimant
Vick & Gutzler, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09049
October 7, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of that portion of Referee Leahy's order that set aside its denial of claimant's current chiropractic treatment. Although claimant has not formally cross-requested review, he argues that the Referee erred in upholding that portion of the aforementioned denial that denied payment for two consulting chiropractic examinations. The issue is medical services.

We affirm that portion of the Referee's order that upheld the employer's denial regarding two consulting chiropractic examinations. We reverse, however, that portion of the Referee's order that set aside the employer's denial of claimant's current chiropractic treatment.

Claimant sustained a compensable left wrist injury in April 1985, while working as a cardboard press operator. His condition was diagnosed as tenosynovitis and his treating physician, Dr. Kiest, placed him on light duty work for two weeks. In November 1985, Kiest concluded that claimant was without permanent impairment.

Thereafter, claimant worked without difficulty until January 1986, when he felt a recurrence of pain in his left wrist. He sought treatment from Dr. Stolzberg, neurologist, who diagnosed mild carpal tunnel syndrome and released claimant to light duty work.

In April 1986, claimant began to treat with Dr. Iatesta, chiropractor. Iatesta diagnosed, "[c]arpal tunnel syndrome * * * with cervicothoracic strain-sprain." Iatesta further remarked that he was treating claimant with "chiropractic spinal adjustments." Two months later, claimant quit his job.

In June 1986, Dr. Nye, hand surgeon, performed an independent medical examination. Nye diagnosed, "improved carpal tunnel symptoms" and felt that claimant required no further medical treatment. Consequently, the employer denied further chiropractic treatment as not "reasonable and necessary [under] ORS 646.245 [sic]."

Thereafter, Dr. Iatesta referred claimant to four

chiropractors for consulting examinations. In June 1986, Iatesta referred claimant to Dr. Vellnave for "evaluation of a left wrist and hand condition." Vellnave diagnosed carpal tunnel syndrome and recommended manipulation and massage therapy. In August 1986, Iatesta referred claimant to Drs. Goe, Cowan, and Eisenbart. Goe diagnosed carpal tunnel entanglement and recommended soft tissue treatments. Cowan diagnosed mild tendinitis of the left wrist and recommended conservative care. Finally, Eisenbart diagnosed carpal tunnel syndrome and recommended continued chiropractic treatment.

In October 1986, Dr. Snodgrass, neurologist, performed an independent medical examination. According to Snodgrass, it was "irrational" to perform chiropractic manipulations of the cervical spine to treat a condition localized at the wrist.

The Referee found that claimant's current chiropractic treatments were compensable. We disagree.

Claimant is entitled to all reasonable and necessary medical services, curative or palliative, so long as they are for conditions resulting from the compensable injury. ORS 656.245(1); West v. SAIF, 74 Or App 317 (1985). It is claimant's burden to prove the reasonableness and necessity of treatment. McGray v. SAIF, 24 Or App 1083 (1976).

Here, Dr. Iatesta is the only medical expert to diagnose a cervicothoracic strain/sprain. Claimant did not complain of any cervical or thoracic problems when examined by the four consulting chiropractors. Dr. Snodgrass felt it was "irrational" to treat claimant's left wrist by spinal manipulation. Claimant has, therefore, not proven that Iatesta's spinal treatment relates to his compensable left wrist injury. ORS 656.245(1).

Dr. Iatesta stated that he treated both the claimant's left wrist and his spine:

> "I have been treating [claimant] using manipulation to the wrist and forearm * * * and chiropractic adjustments to the appropriate spinal segments innervating these areas * * *."

However, Iatesta apparently did not differentiate between spinal and left wrist treatments. Consequently, we are unable to separate Iatesta's treatment of the spine from his treatment of the left wrist. Based on this record, we find that claimant has not proven that his compensable left wrist injury is a material contributing cause of his current need for chiropractic treatment.

ORDER

The Referee's order dated January 22, 1987 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the self-insured employer's denial of claimant's current chiropractic treatment is reversed. In lieu of the Referee's award of attorney fees for services at the hearing on the medical services issues, claimant's reasonable attorney fee is reduced to $400. All remaining portions of the Referee's order are affirmed.

The Beneficiary of
WILLIAM L. MILLER (Deceased), Claimant
Carey & Joseph, Attorneys
Bottini, et al., Defense Attorneys
Marcus Ward, Defense Attorney
Yturri, et al., Defense Attorneys

WCB 86-08797 & 86-09637
October 7, 1987
Order Dismissing Request for Review and Remanding

Liberty Northwest Insurance Corporation has requested review of Referee Foster's Order of Joinder. We have reviewed the request for Board review to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither finally denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the joinder order neither finally disposed of nor allowed the claim. Rather, the order joined several potentially responsible employers/insurers as necessary parties for a future hearing. Since further action before the Hearings Division is required as a result of the joinder order, we conclude that it is not a final appealable order. See Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issue raised by the request for Board review.

Accordingly, the request for Board review is dismissed. This case is remanded to the Hearings Division for further proceedings consistent with the Order of Joinder.

IT IS SO ORDERED.

JOSEPH K. PHILLIPS, Claimant
Michael Dye, Claimant's Attorney
Brian L. Pocock, Defense Attorney

Own Motion 86-0415M
October 7, 1987
Third Interim Own Motion Order Referring Matter for Hearing

Claimant has requested reconsideration of the Board's September 24, 1987 Second Interim Own Motion Order. Pursuant to our order, the employer was directed to pay interim compensation benefits, based on claimant's 1978 temporary total disability rate, commencing effective March 4, 1987 and continuing, less time worked, until claimant is released to regular work, returns to regular work, or his claim is closed pursuant to ORS 656.278. We also awarded claimant's attorney a fee equal to 25 percent of the increased compensation made payable by our order, not to exceed $750.

These benefits were to be paid pending a forthcoming hearing concerning the issue of whether claimant's current condition is attributable to either a 1978 or a 1985 injury, both of which are the responsibility of the employer. See WCB Case Nos. 86-05390 and 86-10171. Referee Knapp has been directed to submit a recommendation concerning the request for Own Motion relief. In addition, should claimant's condition be found attributable to the 1985 injury, the Referee has been instructed to authorize the employer to offset the interim compensation benefits made payable by our order against the temporary disability resulting from the Referee's order.

Contending that the employer has failed to fully comply with our prior orders, claimant now seeks penalties and accompanying attorney fees. Inasmuch as claimant's request emanates from an own motion order, we retain jurisdiction over this matter. David L. Waasdorp, 38 Van Natta 81 (1986). However, issues which could likely have an effect upon this matter are currently pending before the Hearings Division in the aforementioned cases. Under these circumstances, we conclude that this matter shall also be referred to Referee Knapp with instructions to take evidence and entertain arguments concerning this "penalty and attorney fee" issue and to submit his recommendation to the Board. This recommendation shall be in addition to the recommendation discussed in our prior interim own motion orders.

Accordingly, claimant's request for reconsideration is granted and our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 24, 1987 order, effective this date.

IT IS SO ORDERED.

ALBERT ANZALDUA, Claimant
Charles Paulson, Claimant's Attorney
David O. Horne, Defense Attorney

WCB 83-02429
October 8, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Lipton's order that granted claimant permanent total disability. The issue is permanent total disability.

Claimant, 40 at the time of hearing, compensably injured his back and left leg in July 1975. After a course of unsuccessful conservative treatment, he underwent exploratory low back surgery in January 1976. The surgery revealed no sign of a disc herniation, however, and he underwent evaluation at a pain center. In August 1978, his claim was closed by a Determination Order that awarded 10 percent unscheduled permanent disability.

After successfully completing a training program in cosmetology, claimant obtained employment as a hairdresser in November 1978. Due to continuing low back and left leg pain he underwent decompressive surgery at L4-5 and L5-S1 in May 1979. Additional surgeries were performed in January 1980 and November 1981.

Prior to claimant's last surgery, he was examined by the Orthopaedic Consultants. The Consultants rated claimant's "loss of function of the back" as moderate and felt that he could continue work as a hairdresser. The Consultants cautioned, however, that clamant may have to avoid lifting and stooping. In December 1980, a Determination Order and stipulation awarded claimant an additional 40 percent unscheduled permanent disability.

In November 1982, Dr. Pasquesi, orthopedic surgeon, performed a closing examination. Pasquesi rated claimant's physical impairment at 50 percent and recommended sedentary type work. He felt claimant could lift no more than 25 pounds and advised against repetitive bending, stooping, and twisting. In February 1983, a Determination Order awarded 5 percent scheduled permanent disability for radiculopathy into claimant's left leg.

In March 1984, claimant began a training program in office managment and leather work. A few months later, however, he withdrew from the program and left the state to care for his convalescent mother. As a result, a May 1984 Determination Order closed his claim awarding temporary disability only. After his return to Oregon in late 1984, he entered a training program in upholstery. Claimant performed well in the program and consistently received high marks for the quality of his workmanship. Despite increasing back pain, claimant successfully completed the program in April 1986. The next month, Dr. Hill, claimant's treating surgeon, opined that claimant could occasionally lift up to 50 pounds and frequently reach above his shoulders. Hill had previously approved of claimant's release to upholstery work.

Employment in the upholstery field, however, could not be located. Although claimant's participation with return to work assistance was initially described as "minimal," his participation later improved. In August 1986, his vocational counselor, Linda Thornburg, reported that claimant was employable in the upholstery field. Inasmuch as claimant was considered employable and had shown improved job search skills, vocational services were terminated.

Shortly thereafter, claimant experienced a flareup of pain and was seen by Dr. Ferguson, orthopedist. Ferguson felt that it was unlikely claimant could perform work as either an upholsterer or hairdresser. He added, however, that claimant reported performing regular chores at his farm within a 20 pound lifting restriction. In December 1986, Dr. Christopher, orthopedist, performed an independent medical examination. Christopher opined that claimant's residual physical capacity was in the "light to medium range." A final Determination Order issued in January 1987, awarding temporary disability only. A few days later, Dr. Hill reiterated his opinion that upholstery work was within claimant's physical retrictions.

Claimant credibly testified that he can lift up to 35 pounds, sit for one hour, and stand for two hours. He did not believe, however, that he could perform these activities for an eight hour period and he is unaware of any job he could perform on a full time basis. He also stated that he can drive a car and admitted riding his "chopper" style motorcycle a few months prior to the hearing. The vocational counselor, Thornburg, credibly testified that in her opinion claimant was employable as a full time upholsterer and that job site modifications could be used to avoid exceeding his physical restrictions.

The Referee found that claimant was permanently and totally disabled under the "odd lot" doctrine. In so doing, the Referee stated that he was "required" to award permanent total disability because of the unsuccessful attempt by vocational professionals to employ claimant. We disagree.

A worker may prove permanent total disability by showing that he is totally physically or medically incapable of performing regular gainful and suitable employment. See Brech v. SAIF, 72 Or App 388 (1985). Permanent total disability need not, however, derive solely from the worker's medical or physical incapacity. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Accordingly, under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age,

education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985). Generally, disability must be rated as it exists at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). Lastly, under ORS 656.206(3), a worker is required to make reasonable efforts to obtain regular gainful employment, unless it would be "futile" to do so. Butcher v. SAIF, 45 Or App 318 (1983).

We first address whether claimant is permanently totally disabled solely from a medical standpoint. Dr. Hill found that claimant could frequently lift up to 20 pounds and occassionally climb ladders and stairs. According to Hill, claimant can perform upholstery work. Dr. Christopher opined that claimant was capable of light to medium work. Dr. Pasquesi felt that claimant was only 50 percent impaired and capable of sedentary work. Claimant testified that he could lift up to 35 pounds and that he regularly performed minor chores on his farm. Given such facts, we are not persuaded that claimant is permanently and totally physically disabled.

Next we turn to whether claimant has satisfied the "odd-lot" criteria for permanent total disability. In light of the medical and lay evidence, we consider claimant's physical impairment as moderate. At 40 years of age, he is relatively young. He has a G.E.D. certificate and has completed 54 credits of college course work. Vocational testing performed at the Callahan Center reflected slightly above average abilities in reading, spelling, and arithmetic. Accordingly, Dr. Means, Callahan Center psychologist, concluded that claimant could perform "the demands of reading and spelling in a great number of occupations." Claimant has received vocational training in office management, leatherworks, cosmetology, and upholstery. Further, he has worked as a shoe salesman, hairdresser, service station attendant, truck driver, and booster stockman. Finally, psychological testing at the Callahan Center revealed no mental disorder, although claimant did demonstrate "mild" emotional and personalities disturbances.

After de novo review, we find that claimant has transferable skills to light or sedentary work. At 40 years of age, above average reading and writing skills, in excess of one year of college, an ability to lift up to 35 pounds, and a release by his treating physician to perform upholstery work, the evidence does not preponderate in favor of an award of permanent total disability.

Lastly, we rate the extent of unscheduled and scheduled permanent disability for claimant's low back and left leg. The criteria for rating the extent of unscheduled disability is the permanent loss of earning capacity caused by the compensable injury. ORS 656.214(5). Scheduled disability is the loss of use or function of the injured member. ORS 656.214(2). We do not apply the Workers' Compensation Department's administrative rules governing extent of disability in a rigid mechanistic fashion, but rather as guidelines. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Exercising our independent judgment, we find that an award of 50 percent unscheduled permanent disability and 5 percent scheduled disability adequately and appropriately compensates

claimant. Accordingly, claimant is not awarded additional permanent disability.

ORDER

The Referee's order dated February 23, 1987 is reversed.

ALLEN R. BAYLESS, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Mitchell, et al., Defense Attorneys

WCB 86-10086 & 86-06906
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Fireman's Fund Insurance Company requests review of Referee Podnar's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld a denial of claimant's aggravation claim for the same condition issued by Gamble, Inc., a self-insured employer. The issue is responsibility.

Following our de novo review of the record, we agree with the Referee that claimant suffered a new injury, thereby shifting responsibility for claimant's condition to Fireman's Fund. Consequently, we affirm the Referee's order.

Inasmuch as claimant has successfully defended the Referee's responsibility finding in a case where no "307" order has been issued, we conclude that he is entitled to an attorney fee. See Robert L. Montgomery, 39 Van Natta 469 (1987).

ORDER

The Referee's order dated January 29, 1987 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by Fireman's Fund Insurance Company.

SHIRLEY BROCK, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal (Medford), Defense Attorney

WCB 86-03289
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Quillinan's order that set aside its denial of claimant's occupational disease claim for temporomandibular joint syndrome (TMJ). On review, SAIF contends that the claim is not compensable. We agree and reverse.

Claimant, 55 years old at the time of the hearing, has been employed as a receptionist since 1982. Her job requires a great deal of public contact, periodically necessitating exchanges with agitated and volatile people. In addition, claimant experienced conflicts with her prior supervisor, partially attributable to an increased work load. Claimant has also had several potential off-the-job stressors, including a recent marriage, buying a new home and beginning a remodeling project. In 1985 she filed a claim for on-the-job stress and tension manifested by pain in the jaw, head and neck. Claimant contends that her work conditions were the major contributing cause of her stress leading to the TMJ syndrome.

Dr. Shirtcliff, claimant's treating dentist, diagnosed TMJ

dysfunction with associated myofascial pain syndrome. A bite splint was prescribed, which relieved claimant's symptoms. Dr. Shirtcliff noted that claimant had two TMJ conditions. The first was TMJ dysfunction, which is a true dysfunction of the joint itself. The second was TMJ syndrome, which is the result of muscle spasms in the jaw, head and neck. According to Dr. Shirtcliff, the most common reason for muscle spasms is teeth clenching, which seems to go "hand in hand with stress." He did not, however, explain what caused claimant's stress.

In January 1986 claimant was examined by Dr. Holland, psychiatrist, who described claimant's overall and environmental stress level as "low/optimal." Dr. Holland stated that since claimant's TMJ syndrome was relieved by the bite splint, her symptoms were more likely related to an organic cause, similar to her TMJ dysfunction. Moreover, based on the objective medical evidence, Dr. Holland concluded that claimant suffered from a TMJ syndrome that could not be severed from her TMJ dysfunction.

Dr. Holland acknowledged that claimant experienced stress from her job. Yet, Dr. Holland did not consider the stress to be the major contributing cause of claimant's TMJ syndrome. Furthermore, Dr. Holland opined that claimant's stress may have rendered her preexisting TMJ dysfunction symptomatic but it did not cause a worsening of the condition.

The Referee found that claimant's TMJ syndrome was compensable. We disagree. We are not persuaded that claimant's work activities either caused or worsened her TMJ dysfunction or syndrome.

To establish an occupational disease claim, claimant must prove that her work activities were the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570, rev den 292 Or 825 (1982). If claimant's condition preexisted her employment, she must also prove that her work activities caused a worsening of her underlying condition. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979).

Here Dr. Shirtcliff proffered no medical opinion or evidence that claimant's TMJ dysfunction or syndrome was caused or worsened as a result of stressful work activities.

Claimant argues that she is seeking compensation only for TMJ syndrome. However, Dr. Shirtcliff characterized claimant's TMJ syndrome as a conglomeration of pain symptoms. Furthermore, Dr. Holland noted that medical studies had determined that the TMJ syndrome has no pathophysiologic process and could not be separated from TMJ dysfunction. Inasmuch as the medical evidence fails to establish that claimant's TMJ dysfunction was either caused or worsened by her work activities, we conclude that the claim is not compensable.

Finally, assuming that claimant's condition was attributable to stress, the evidence fails to preponderate that her stressful work activities were the major contributing cause of the condition or its worsening.

ORDER

The Referee's order dated January 27, 1987 is reversed. The SAIF Corporations's denial is reinstated.

BRIAN W. JOHNSTON, Claimant
Patrick K. Mackin, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-01069
October 8, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Quillinan's interim order that denied a motion to compel claimant's appearance at an independent medical examination. In addition, the employer requests review of those portions of Referee Quillinan's order that: (1) set aside its June 2, 1986 denial of claimant's May 1986 aggravation claim and ongoing treatment for his back condition; and (2) set aside its May 13, 1986 denial of medical treatment. Should we reverse the Referee's "aggravation" finding, the employer requests that the claim be remanded or, in the alternative, additional briefs be allowed concerning the extent of claimant's permanent disability. Claimant cross-requests review of that portion of the order that: (1) upheld the employer's May 13, 1986 denial of claimant's January 1986 aggravation claim; and (2) declined to assess penalties and attorney fees for unreasonable denials of aggravation and medical service claims. The issues are aggravation, medical services, whether claimant was requird to attend an independent medical examination, extent of unscheduled permanent disability, remand, penalties and attorney fees.

In September 1983 claimant suffered a compensable injury to his low back. Dr. Ferrante, chiropractor, diagnosed thoracolumbar sprain/strain with moderate to severe myofascitis and released claimant from work. In November 1983, claimant underwent an independent medical examination with Dr. Gatterman, chiropractor. Dr. Gatterman concurred in the diagnosis of lumbar strain and felt claimant would benefit from six to eight weeks of chiropractic care, at which time claimant could return to regular work. Gatterman noted that claimant was markedly obese and would benefit from a concerted weight loss effort. Ferrante concurred, also recommending that claimant enroll in a weight loss program.

In January 1984 claimant underwent a Fitness Profile Analysis. His weight had increased from 217 pounds at the time of the injury to 235 pounds. Claimant's overall fitness level was low. In April 1984, Dr. Ferrante released claimant for light duty. Dr. Asbury, osteopath, examined claimant and found him medically stationary with undetermined impairment. On June 15, 1984, Dr. Ferrante declared claimant medically stationary. However, on June 24, 1984 claimant experienced an exacerbation and Dr. Ferrante released him from regular work. In August 1984 Dr. Bachhuber, orthopedist, examined claimant and diagnosed chronic postural backache aggravated by obesity. Dr. Bachhuber found claimant capable of performing regular work and recommended back exercises. He noted that it was "undetermined" if claimant's condition was related to work.

In September 1984, Dr. Ferrante declared claimant medically stationary with estimated permanent impairment of 15 percent and a lifting limitation of 10 to 15 pounds. Claimant experienced exacerbations and was again released from work for periods in October and November 1984. In November 1984 claimant was examined by Dr. Bachhuber at the insurer's request. Dr. Bachhuber found claimant medically stationary with no permanent impairment. He considered claimant not to be highly motivated and doubted his ability to lose weight even with a

supervised program. In December 1984 claimant underwent a nutritional consultation at Providence Medical Center, where it was noted he had gained 18 pounds since his injury.

Also in December 1984, the Orthopaedic Consultants examined claimant and diagnosed: (1) obesity; (2) lumbosacral contusion and strain by history; and (3) chronic postural low back pain. The Consultants found no orthopedic or neurologic evidence of permanent impairment. Because claimant was still undergoing the weight loss program, the Consultants did not consider him stationary. In April and May 1985, Determination Orders issued awarding claimant no permanent disability.

In June 1985, Dr. Ferrante reported that claimant's condition had worsened as of May 13, 1985. Dr. Bachhuber reported on July 9, 1985 that claimant was significantly obese and suffered from a postural backache. Further, he opined that claimant had incurred no impairment as a residual of his work injury and that claimant's disability would decrease if he would lose weight. In July 1985, by stipulation, the insurer accepted claimant's aggravation claim. On October 17, 1985, claimant was examined by BBV Medical Services. Drs. Barth, neurologist, and Martens, orthopedist, diagnosed: (1) obesity; (2) lumbar strain by history, resolved; and (3) no functional abnormalities. The physicians reported that claimant was totally asymptomatic and required no treatment. Whereas claimant had weighed 217 pounds at the time of his injury, the doctors noted that he currently weighed 257 pounds. Responding to the report of BBV Medical Services, Dr. Ferrante stated that claimant's obesity only complicated his recovery, but that his 1983 industrial injury remained the cause of his disability.

In December 1985 a Determination Order issued that awarded no permanent disability. A modified Determination Order issued in January 1986 that awarded 10 percent unscheduled permanent disability.

Claimant asserts that his condition worsened on January 11, 1986, following an incident of increased back pain after getting out of his car. On January 30, 1986, he was examined by Dr Stevens, orthopedist, who diagnosed probable posttraumatic, degenerative disc disease with chronic obesity. Dr. Stevens later noted that the predominant factor in claimant's current symptoms was his obesity and not the back strain. A March 1986 CT scan suggested some narrowing of the right L5 neural foramen at the L5-S1 level. In April 1986 Dr. Stevens stated that he felt the January incident was independent from claimant's 1983 industrial injury and was more likely related to his chronic obesity. On May 13, 1986, the insurer denied the claim for aggravation and medical treatment, stating that claimant's condition was not related to his industrial injury.

Thereafter, claimant changed his treating physician to Dr. Michels, chiropractor. On May 22, 1986, Dr. Michels indicated that claimant's condition had worsened and released claimant from work. The insurer also denied this claim for aggravation and medical services, again stating that claimant's condition was not related to his industrial injury. On July 10, 1984, Dr. Michels reported that, as a result of his industrial injury, claimant suffered from myofascitis and scarring of the paravertebral muscles. He recommended thermography. On July 11, 1986 Dr. Barth

reviewed claimant's file and noted that claimant's condition must have changed since during his 1985 examination he was asymptomatic and required no treatment. Relying on Dr. Stevens' reports, Dr. Barth concluded that claimant's current back condition was not industrially related. On July 16, 1986, Dr. Hubbard, neurosurgeon, examined claimant and noted that he suffered from "predominantly low back fatigue symptoms." He recommended physical therapy, vocational rehabilitation and weight loss.

On July 21, 1986, the insurer filed a motion to compel claimant to attend an independent medical examination. Claimant objected to the examination stating that the insurer had exceeded the three independent examinations permitted by ORS 656.325(1). ORS 656.325(1) states in relevant part:

> "Any worker entitled to receive compensation under ORS 656.001 to ORS 656.794 is required, if requested by the director, the insurer or self-insured employer, to submit to a medical examination at a time and from time to time at a place reasonable convenient for the worker and as may be provided by the rules of the director. However, no more than three examinations, excluding examinations by consulting physicians, may be requested except after notification to and authorization by the director."

At that time claimant had been examined at the employer's request by the following physicans on the following dates: (1) November 23, 1983, Dr. Gatterman; (2) December 21, 1984, Orthopaedic Consultants; (3) November 15, 1985, Dr. Bachhuber; and (4) November 17, 1985, BBV Medical Services. Absent approval of the medical director pursuant to OAR 436-10-100, the Referee concluded the insurer had exceeded the number permitted by ORS 656.325. Consequently, the insurer's motion was denied.

On September 2, 1986 Dr. Hubbard stated that claimant did suffer a backache from his September 1983 compensable injury. However, like Dr. Stevens, Dr. Hubbard noted that claimant had experienced periods of complete relief since the original injury. Dr. Hubbard concluded that claimant's chronic obesity was the likely cause of his recurrent backache problems. He could find no objective findings that supported claimant's ongoing low back complaints. In October 1986 Dr. Michels stated that the worsening of May 19, 1986 was not related to the January 1986 incident. Dr. Michels continued to relate claimant's ongoing complaints to his 1983 injury. He stated that the type of soft tissue injury experienced by claimant results in fibrotic repair tissue. The fibrotic repair tissue is weaker than ordinary tissue and is therefore more susceptible to reinjury. Claimant's periods of relief followed by exacerbation, in Dr. Michels' opinion, were typical of this type of injury.

We reverse the Referee's interim order denying the employer's motion for claimant to attend an independent medical examination pursuant to ORS 656.325(1). In denying the request, the Referee counted the number of examinations and concluded that over the course of the entire claim, the insurer had at least three. We conclude that ORS 656.325(1) does not apply solely to the entire life of a claim. We conclude that ORS 656.325(1)

permits new independent medical examinations each time claimant presents an aggravation claim arising from a new aggregate of operative facts. The aggravation claim involves a separate request for relief emanating from new facts. Consequently, we interpret ORS 656.325(1) as not precluding the employer additional independent medical examinations.

Here, claimant filed aggravation claims alleging that his condition had worsened. Notably, none of the employer's prior independent medical examinations were conducted after either of the two aggravation claims. Therefore, these prior medical examinations were of minimal relevance. We conclude that the facts surrounding the worsening constituted an aggregate of new operative facts. Consequently, following the January 1986 aggravation claim, the employer was entitled to additional independent medical examinations pursuant to ORS 656.325. Yet, since we conclude that claimant's aggravation claim is not compensable, remand is not necessary for additional independent medical examinations.

We reverse that portion of the Referee's order that set aside the employer's May 22, 1986 denial of medical treatment for claimant's back condition. Virtually every physician that has examined claimant, save Drs. Michels and Ferrante, have stated that his current condition is not related to his original injury.

We find the medical reports of Drs. Stevens and Hubbard most persuasive. Dr. Stevens examined claimant following the alleged January 1986 aggravation and Dr. Hubbard examined claimant following the alleged May 1986 aggravation. Neither physician found claimant's current need for treatment or disability related to his industrial injury. Consequently, we conclude that the employer's denials of aggravation and medical services should be upheld.

Finally, we find the record sufficiently developed that remand is not necessary for purposes of rating the extent of claimant's permanent disability. See ORS 656.295(3). Because we find claimant's current disability and need for medical treatment unrelated to his industrial injury, we conclude that claimant is not entitled to an award of unscheduled permanent disability. Consequently, claimant's prior award of 10 percent unscheduled permanent disability is set aside.

ORDER

The Referee's order dated November 13, 1986 is reversed in part and affirmed in part. The self-insured employer's May 13, 1986 denial of medical services is reinstated and upheld. The employer's June 2, 1986 denial of claimant's aggravation and medical services claim is also reinstated and upheld. Claimant's attorney fee award concerning these issues is reversed. The January 1986 Determination Order's award of 10 percent (32 degrees) unscheduled permanent disability is reversed. The remainder of the order is affirmed.

ROY M. JOHNSTON, Claimant
Malagon & Moore, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 85-13546
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Foster's order that set aside its denial of claimant's occupational disease claim for a respiratory disorder. The issues are the timeliness of the claim, compensability and responsibility.

Claimant began working for the employer in 1972, when it was insured by Wausau Insurance Company. Claimant worked on a line, wrapping rolls of paper products in cellophane. This process gave rise to a considerable amount of fine paper dust in the air. Claimant began to have respiratory difficulty within a short time and first sought medical treatment in 1973. Since that time, he has continued to perform the same job with periodic respiratory flareups.

In July 1982, the self-insured employer purchased claimant's previous employer. Claimant continued to work in the same position and to experience breathing difficulty. In June 1985, Dr. Hartman, claimant's treating family practitioner, recommended that he no longer work in a place where he would be exposed to paper dust. The employer had no such position available for claimant and so claimant did not return to work. Claimant filed a workers' compensation claim in August 1985. Within a few months of leaving work, claimant's symptoms totally resolved.

The Referee found claimant's claim timely, found his condition compensable and found the self-insured employer responsible. The latter two conclusions were based upon a finding that claimant's employment after the self-insured employer came on the risk in 1982 had pathologically worsened his disease.

We reverse the order of the Referee on the compensability issue. Claimant's condition has been variously diagnosed, but the most convincing diagnosis in the record is that of hyperreactive airways disease. According to Dr. Wilson, an allergy specialist, this condition is hereditary and would have preexisted claimant's employment in 1972. It involves an abnormal sensitivity of the air passages to dust, fumes, exhaust and other irritants. Exposure to such irritants renders the condition symptomatic, but once the irritant is removed, the symptoms subside without a worsening of the underlying condition. Given these facts, the present case is indistinguishable from Wheeler v. Boise Cascade Corp., 298 Or 452 (1985), and we conclude that claimant's condition is not compensable for the reasons stated in that case.

A portion of the Referee's order awarded claimant's attorney an attorney fee of $300 for establishing a claims processing violation. Although claimant's condition is not compensable and there is no compensation from which to assess a penalty, claimant's attorney is entitled to a fee under the rule of Spivey v. SAIF, 79 Or App 568, 572 (1986).

ORDER

The Referee's order dated August 22, 1986 is affirmed in part and reversed in part. That portion of the order that awarded claimant's attorney an attorney fee of $300 in connection with a claims processing violation is affirmed. The remainder of the order is reversed. The self-insured employer's denial is reinstated.

GERALD J. KAMPH, Claimant
Malagon & Moore, Claimant's Attorneys
Bottini, et al., Defense Attorneys

WCB 86-08887
October 8, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Safeco Insurance Company requests review of those portions of Referee Nichols' order that: (1) declined to dismiss claimant's request for hearing as barred by either res judicata or collateral estoppel; and (2) set aside its denial of claimant's occupational disease claim for a low back condition. The issues are jurisdiction and compensability/responsibility.

We affirm the Referee on the jurisdiction issue. We reverse, however, that portion of the Referee's order that set aside Safeco's denial of claimant's occupational disease claim.

Claimant, 31 at the time of hearing, sustained a compensable right arm and back injury in May 1984. At that time, he was working for a former employer insured by Liberty Northwest Insurance Corporation. He received emergency hospital treatment for a right arm fracture and low back contusion. Dr. Bert, orthopedist, treated conservatively and released claimant to regular work in August 1984. Despite continuing low back pain, claimant resumed his truck and forklift driving duties.

In January 1985, claimant began working for Safeco's insured who, at that time, was insured by a carrier other than Safeco. His job consisted of driving a truck eight to 12 hours a day, five to six days a week. Claimant's low back discomfort gradually increased.

In April 1985, Safeco came on the risk. Two weeks later, claimant's back pain became so severe that he could not continue working. Within the next few months, he developed radiculopathy associated with numbness and tingling into the right leg. A CT scan performed in September 1985 showed signs of a bulging disc at L4-5. That same month, Dr. Bert informed Liberty that claimant had sustained an aggravation of his May 1984 injury. Liberty asserted the "last injurious exposure rule" and denied responsibility for reopening claimant's claim, as well as payment for further medical services.

In February 1986, claimant was examined by Dr. MacRitchie, medical rehabilitation specialist. MacRitchie opined that although claimant's back injury had been greatly aggravated by his work activities with Safeco's insured, his continued complaints were "a direct result" of his May 1984 injury. The following month, Dr. Bert was deposed. According to Bert, claimant's truck driving activities for Safeco's insured contributed to his bulging disc. However, Bert also stated that the May 1984 injury remained a material contributing cause of claimant's need for medical treatment.

Claimant appealed Liberty's denial and went to hearing before Referee Howell in March 1986. The only parties to that

proceeding were claimant and Liberty. Referee Howell found that claimant had sustained a "new injury" while employed with Safeco's insured and, therefore, upheld Liberty's denial of claimant's aggravation claim. Referee Howell's order was apparently not appealed.

Subsequently, claimant filed an occupational disease claim against Safeco. In June 1986, Safeco denied compensability, asserting that: (1) claimant's occupational disease claim had not been timely filed; and (2) collateral estoppel barred further proceedings. Claimant timely appealed Safeco's denial.

In September 1986, Dr. Bert opined that "the major contributing factor to [claimant's] present problem and the major causative factor was his injury in 1984."

Claimant testified that his back pain continued after his May 1984 injury. He stated that his back gradually worsened until he could no longer perform his truck driving duties. Near the end of his employment with Safeco's insured, claimant felt that his back condition changed with new pain into the right hip and buttocks. He testified that he did not initially file a claim with Safeco's insured because he did not think Safeco was responsible. One of claimant's co-workers, a dispatcher, testified that claimant made no complaints of back pain or injury while employed with Safeco's insured.

The Referee analyzed this case as solely a responsibility issue. Concluding that claimant had sustained a worsening of his underlying condition, the Referee set aside Safeco's denial. We disagree.

In our view, this case presents a question of compensability, not responsibility. Neither the "last injurious exposure rule" nor the "last injury rule" apply when compensability remains at issue. See Smith v. Ed's Pancake House, 27 Or App 361 (1976); Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

Here, compensability was at issue. Claimant filed an occupational disease claim against Safeco. No other insurers were joined as parties. Without waiving other issues of compensability, Safeco denied the claim on the basis of timeliness and jurisdiction; not responsibility. Accordingly, claimant was not absolved of his burden to prove compensability.

To establish an occupational disease claim, claimant must prove that his work activities at Safeco's insured were the major contributing cause of his low back condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). If claimant's condition preexisted his employment at Safeco's insured, he must also prove that his work activities caused a worsening of his underlying condition producing disability or the need for medical services. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Although claimant's testimony concerning causation is probative, it may not be persuasive when the issue involves a complex medical question. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, neither Drs. MacRitchie nor Bert indicated that claimant's work activities at Safeco's insured were the major contributing cause of his low back condition or the worsening thereof. To the contrary, Dr. MacRitchie opined that claimant's complaints were "a direct result" of his May 1984 injury. Similarly, Dr. Bert stated that the May 1984 injury was "the major

contributing factor" to claimant's present problem. Although claimant testified that he felt new pain into the right hip and buttock, he also stated that his symptoms continued to worsen following his May 1984 injury. After our de novo review of the medical evidence and lay testimony, we are unpersuaded that claimant's work activities at Safeco's insured were the major contributing cause of his back condition or the worsening thereof.

ORDER

The Referee's order dated November 12, 1986 is reversed in part and affirmed in part. That portion of the Referee's order that set aside Safeco Insurance Company's denial is reversed. All remaining portions of the Referee's order are affirmed.

JAMES L. LANCE, Claimant
Steven Yates, Claimant's Attorney
Kevin Mannix, Defense Attorney
Davis, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
Garrett, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Richard Butler, Attorney
Dean Sandow, Attorney
Marcus Ward, Attorney
Gary Jones, Attorney
Schwabe, et al., Attorneys
Mitchell, et al., Attorneys
David Horne, Attorney
William Beers, Attorney
Roberts, et al., Attorneys

WCB 86-00279, 86-05948, 86-05102, 86-05103, 86-05104, 86-05105, 86-05106, 86-05107, 86-05108, 86-05109, 86-05110, 86-05111, 86-05112, 86-05113, 86-05114, 86-05115, 86-05116, 86-05117, 86-05118, 86-05119, 86-05120, 86-05121, 86-05122, 86-05123 & 86-05124

October 8, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Standard Fire Insurance Company (Standard Fire) requests review of Referee Foster's order that set aside its denial of compensability and responsibility for claimant's left knee claim. The issues are compensability and responsibility.

The Board affirms the order of the Referee with the following comment.

Claimant, an iron worker, sustained a compensable injury to his left knee in 1977 while working for the R.A. Gray Company. The claim was closed by a July 1978 Determination Order that awarded claimant a total of 5 percent scheduled permanent disability for the loss of function of the left knee. A Referee's order increased the award to 15 percent scheduled permanent disability. Following the award, claimant continued to work as an iron worker, employed by numerous employers for varying periods of time. Claimant experienced no new incidents of trauma to the left knee following the original incident.

In September 1985 claimant began treating with Dr. Buttler, chiropractor, for left knee pain. In December 1985 the Orthopaedic Consultants diagnosed severe posttraumatic arthritis of the left knee. The Consultants noted a significant worsening in claimant's condition since the original 1977 injury. The medical opinions of Drs. Buttler, Watson and Wilson indicate that claimant's subsequent employment as an iron worker at the

various employers all contributed to the gradual worsening of his left knee condition. Standard Fire's insured was the last of claimant's employers against whom he filed a claim.

In March 1986 claimant filed an aggravation claim with the R.A. Gray Company. He also filed occupational disease claims with the 26 employers he had worked with since the original injury. All the claims were denied on the basis of responsibility and/or compensability. Claimant timely appealed the denials.

In order to establish the compensability of his left knee condition as an occupational disease, claimant had the burden to prove that his work activities were the major contributing cause of the worsening of his underlying condition. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Here, there is no serious contention that claimant's work activities at the various employers following his original injury were not the major contributing cause of the worsening of his knee condition. Consequently, claimant has established that his knee condition is compensable as either a new occupational disease or aggravation of his previous 1977 injury.

We turn to the issue of responsibility.

Recognizing that claimant's work activities following the original injury resulted in a gradual worsening of his condition, the Referee analyzed the responsibility issue as successive occupational diseases and determined that Standard Fire's insured was responsible as the last employer whose work exposure could have contributed to claimant's knee condition. Although we agree that Standard Fire's insured is responsible, we disagree with the Referee's analysis.

Claimant suffered a compensable injury to his left knee followed by the gradual deterioration of that condition. In determining responsibility, we first must decide whether the claim should be analyzed as successive injuries or successive occupational diseases. In Crowe v. Jeld-Wen, 77 Or App 81, 85-86, (1985) the court stated that "[t]he fact that activity at the second employment causes a condition acquired in the first employment to flare up or worsen does not convert the occupational injury into an occupational disease." Since claimant's initial knee claim was an injury, responsibility is analyzed using the standards applicable for successive injuries. Consequently, responsibility rests with the last employer that independently contributed to the causation of the disabling condition, i.e., to a worsening of the underlying condition. Hensel Phelps Const. Co. v. Mirich, 81 Or App 290, 294 (1987). See Crowe v. Jeld Wen, supra. 77 Or App at 86.

The medical evidence and lay testimony indicate that all of claimant's employment following his original injury incrementally contributed to the worsening of his condition. Standard Fire's insured was the last employer that independently contributed to the condition. Therefore, Standard Fire is responsible for claimant's knee condition.

Standard Fire attempts to avoid responsibility by asserting that claimant worked for other employers after leaving the employ of its insured. These employers were not joined and did not have claims filed against them. Standard Fire contends that these last employers independently contributed to claimant's

condition and therefore it is not responsible. However, since the Referee's decision, the Supreme Court decided the case of Runft v. SAIF, 303 Or 493 (1987). In Runft, the court held that once a claimant has established compensability, the last injurious exposure rule cannot be used defensively to defeat claimant's entitlement to compensation unless subsequent employers are joined. See also Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). We find the legal reasoning of Runft directly applicable. Consequently, without joining the subsequent employers, Standard Fire cannot assert the last injurious exposure rule defensively to defeat claimant's claim.

ORDER

The Referee's order dated October 17, 1986 and November 3, 1986, as supplemented, is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the Standard Fire Insurance Company.

DAVID E. NOBLE, Claimant
Bloom, et al., Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-10387 & 86-10108
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Neal's order that: (1) upheld the insurer's denial of claimant's back condition; (2) found that claimant's claim was not prematurely closed; (3) determined claimant was neither entitled to temporary disability from January 24, 1986 to August 20, 1986 nor a related penalty and attorney fee; (4) declined to assess a penalty and attorney fee for the insurer's failure to pay medical services during a pending review of a prior Referee's order; and (5) determined that the Referee lacked jurisdiction to consider claimant's entitlement to vocational services. In his brief, claimant further asserts that the insurer's failure to pay medical services following the prior Referee's order was improper in that ORS 656.313(4) is unconstitutional. The issues are compensability, premature claim closure, temporary disability, jurisdiction, vocational services, constitutionality, penalties and attorney fees.

We reverse that portion of the Referee's order that declined to award temporary disability following the prior Referee's order.

In May 1986 a prior Referee set aside the insurer's denial of claimant's injury claim for his right knee condition. Before the issuance of the prior Referee's order, Dr. Nelson, claimant's treating physician, had stated that claimant was medically stationary on January 24, 1986. Immediately following the prior Referee's order, the insurer requested the issuance of a Determination Order. In addition, relying on our decision in Sharon Bracke, 36 Van Natta 1245 (1984) rev'd on other grounds 78 Or App 128 (1986), the insurer refused to pay temporary disability after January 24, 1986, the date claimant was declared medically stationary.

On August 20, 1986, a Determination Order issued, awarding temporary disability from October 9, 1985 until January 24, 1986. At hearing, claimant sought the payment of temporary disability from January 24, 1986 until the August 1986 Determination Order and a

penalty and attorney fee for the insurer's unilateral termination. The Referee concluded that the insurer had correctly followed the Board's decision in Bracke, and declined to order the payment of additional temporary disability after January 24, 1986 or a related penalty and attorney fee.

We find that claimant is entitled to additional temporary disability.

An employer or insurer must continue to pay temporary disability compensation to an injured worker whose claim is in open status until the worker returns to regular work, is released by the attending physician to return to regular work or "until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division." ORS 656.268(2); Volk v. SAIF, 73 Or App 643 (1985); Jackson v. SAIF, 7 Or App 109 (1971). In Bracke, we noted an additional method in which temporary disability may be terminated for claims in which compensability has been denied. We held that within 14 days of an Opinion and Order finding a claim compensable, the insurer need only pay temporary disability until claimant has been "declared (as opposed to being determined under ORS 656.268) to be medically stationary." Bracke, supra, 36 Van Natta at 1248. On several subsequent occasions, we have stated that this exception was of "dubious precedential value." A.G. McCullough, 39 Van Natta 65 (1987); Richard M. Deskins, 38 Van Natta 494, 497 (1986). We now conclude that the exception outlined in Bracke is inconsistent with ORS 656.268 and its interpretation under prevailing case law. Consequently, we disavow its holding.

Here, following the prior Referee's order, claimant had not returned to regular work, been released to regular work or had his claim closed pursuant to ORS 656.268. Therefore, claimant is entitled to temporary disability between January 24, 1986 and the issuance of the Determination Order on August 20, 1986. However, we decline to award a penalty and attorney fee for the insurer's unilateral termination. At the time of the prior Referee's order, Bracke remained a valid, if dubious, method of terminating temporary disability. We find that the insurer's reliance on Bracke was not unreasonable within the meaning of ORS 656.262(10). Consequently, a penalty and attorney fee are not warranted.

We also affirm the Referee's finding that penalties and attorney fees are not warranted for the insurer's failure to pay medical benefits pending review of the prior Referee's finding of compensability. In addition to the Referee's findings, we offer the following comment. The prior Referee set aside the insurer's denial of compensability and responsibility. Pending Board review of that order, the insurer withheld payment of claimant's medical bills pursuant to ORS 656.313(4). On appeal, claimant asserts that ORS 656.313(4) is unconstitutional. The Board is without authority to decide constitutional issues. Ray Lynn York, 35 Van Natta 558 (1983); But, See Jane Goodman, 38 Van Natta 1374 (1986). Under these circumstances, we decline to address the question of the statute's constitutionality.

We affirm the remainder of the Referee's order.

ORDER

The Referee's order dated October 20, 1986 is affirmed in part and reversed in part. That portion of the Referee's order that

declined to award temporary disability from January 24, 1986 until the August 20, 1986 Determination Order is reversed. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order. However, the total of fees approved by the Referee and the Board concerning the extent of temporary disability issue shall not exceed $3,000. The remainder of the Referee's order is affirmed.

TED W. PECKHAM, Claimant
Coons & Cole, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-00033
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Mongrain's order that declined to award temporary disability for the period he was incarcerated in a state correctional facility. The issue is temporary disability.

The Board affirms the order of the Referee with the following comment.

Claimant suffered a compensable injury to his back in September 1983. From October 1984 to June 1985 claimant was incarcerated in a state correctional facility. During that period, claimant had not returned to regular work, been released to regular work nor determined medically stationary by the Evaluation Division. The insurer paid temporary total disability to claimant for the period he was incarcerated. See Jackson v. SAIF, 7 Or App 109 (1971); Lloyd O. Fischer, 39 Van Natta 5 (1987). A December 1985 Determination Order awarded claimant permanent partial disability, but did not award temporary disability for the period he was in the correctional facility. The Determination Order also authorized the offset of overpaid temporary disability from unpaid permanent disability. Accordingly, the insurer offset the temporary disability paid while claimant was incarcerated against his award of permanent disability.

Claimant seeks the payment of temporary disability for the period he was incarcerated. The Referee relied on Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), and concluded that once incarcerated, claimant was no longer available for work and, therefore, could not sustain a loss of wages. Consequently, the Referee determined that claimant was not entitled to temporary total disability and approved the offset. We agree.

Claimant asserts that Cutright applies only to workers who voluntarily remove themselves from the labor force. Since he was involuntarily incarcerated, claimant contends Cutright does not apply. We are not persuaded by this analysis. Noting that temporary total disability is wage replacement for "workers" as defined by ORS 656.005(28), the Cutright Court stated that "[t]here is not one word in the statute that refers to a person who no longer engages in furnishing services for remuneration." Id. at 297; See also Karr v. SAIF, 79 Or App 250, 253 (1980) (A person who has withdrawn from the work force, for whatever reason, has no lost wages and is not entitled to temporary total disability payments.)

Voluntarily retired workers are only one category of persons no longer furnishing services for remuneration. Inasmuch as claimant was no longer engaged in furnishing services for remuneration, we conclude that he did not qualify as a worker for the purposes of obtaining temporary total disability during the period of his incarceration.

ORDER

The Referee's order dated October 1, 1986 is affirmed.

GUY M. SHORB, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-01926
October 19, 1987
Corrected Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Nichols' order that granted claimant an award of permanent total disability in lieu of previous awards of 100 percent (150 degrees) scheduled permanent partial disability for each leg and 60 percent (192 degrees) unscheduled permanent partial disability for his central nervous system. SAIF also contends that the Referee erred in excluding a number of exhibits and in not authorizing an offset of the permanent partial disability awards against the award of permanent total disability. The issues are evidence, extent of disability and offset.

The Board affirms the order of the Referee with the following modification concerning the offset issue. We agree with SAIF that it is entitled to an offset of permanent partial disability paid between the effective date of the permanent total disability award and the date of the Referee's order. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 31-32 (1983); Donald V. Wilkinson, 37 Van Natta 937 (1985).

This corrected order replaces the Board's October 8, 1987 order, which is withdrawn.

ORDER

The Referee's order dated January 5, 1987 is affirmed in part and modified in part. The SAIF Corporation may offset permanent partial disability benefits paid after June 11, 1986, against the award of permanent total disability. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review concerning the permanent total disability issue, to be paid by the SAIF Corporation.

ROSALINDA VILLARREAL, Claimant
Churchill, et al., Claimant's Attorneys
Cliff, Snarskis & Yager, Defense Attorneys
Beers, et al., Defense Attorneys

WCB 85-07831 & 85-07832
October 8, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Myers' order that rejected her request for an attorney fee from EBI Companies in connection with that portion of its denial relating to the compensability of her left wrist condition. Another insurer was ultimately found responsible for that condition. The issue is attorney fees.

Since the date of the Referee's order, the Board has ruled that an attorney fee is awardable against the nonresponsible insurer under the circumstances of this case. Karen J. Bates, 39 Van Natta 42, 39 Van Natta 100 (1987). That portion of the Referee's order that rejected claimant's request for an attorney fee against EBI, therefore, shall be reversed.

ORDER

The Referee's order dated December 17, 1985, as supplemented by the Order on Reconsideration dated January 15, 1987, is reversed in part. That portion of the order that rejected claimant's request for an attorney fee against EBI Companies on the issue of compensability is reversed. Claimant's attorney is awarded an attorney fee of $500, to be paid by EBI. The remainder of the Referee's order is affirmed.

RICHARD M. BURWELL, Claimant
Schwabe, et al., Defense Attorneys

WCB 86-13521 & 86-13520
October 12, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Tuhy's order that: (1) affirmed an October 27, 1986 Determination Order which closed claimant's claim for his low back condition; and (2) awarded 15 percent (48 degrees) unscheduled permanent partial disability for the same condition, whereas the Determination Order had declined to award permanent disability. On review, the issues are: (1) premature claim closure, and (2) the extent of unscheduled permanent partial disability.

Claimant has submitted medical reports which were generated post-hearing. Submission of additional material, not otherwise in the record, is treated as a request for remand for the taking of additional evidence. Judy A. Britton, 37 Van Natta 1262 (1985). The request is denied. After conducting our de novo review, we find that the record has not been "improperly, incompletely or otherwise insufficently developed." See ORS 656.295(5).

Turning to the merits, we affirm the order of the Referee.

ORDER

The Referee's order dated December 31, 1987 is affirmed.

LORINE F. CRUMMETT, Claimant
SAIF Corp Legal, Defense Attorney

WCB 85-12846
October 12, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Knapp's order that upheld the SAIF Corporation's denial of her occupational disease claim for a stroke. Some of the materials claimant submits on review are not otherwise in the hearing record. We treat the presentation of these materials as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and whether claimant was a subject worker.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

After de novo review, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the additional evidence presented in claimant's brief was obtainable with due diligence. Accordingly, we find that remand is not warranted.

On the merits, the Board affirms the order of the Referee.

ORDER

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

HARRY N. HUNSLEY, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-02203
October 12, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Brown's order that: (1) declined to consider a vocational report unless the hearing was postponed; (2) awarded claimant an additional 10 percent (32 degrees) unscheduled permanent disability for his upper back and left shoulder condition, in addition to a previous award of 40 percent (128 degrees) by way of two Determination Orders; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable delay in authorizing and in paying for certain massage therapy treatments. Claimant further requests that we remand this case to the Hearings Division for consideration of the aforementioned vocational report. The threshold issue is evidentiary and whether remand is appropriate.

The hearing convened on June 25, 1986. At the hearing, claimant sought to admit a vocational report dated June 24, 1986. The insurer objected to the admission of the report on the grounds that OAR 438-07-005(3)(b) (Since amended April 15, 1987) was not intended to cover vocational reports submitted for litigation purposes. In the alternative, the insurer requested the right to either respond or cross-examine the author of the report. Claimant replied that the report had been timely submitted under the Board's Administrative Rules and that he had no objection to the insurer's request for cross-examination.

The Referee ruled that the report had been appropriately submitted pursuant to the Rule. However, the Referee was unwilling to hold the record open for cross-examination of the report's author. Rather than leave the record open, the Referee sought to postpone the hearing. Faced with a postponement, claimant "withd[rew]" the vocational report in order to proceed to hearing, while "offer[ing]" the report under the Rule. The Referee then "admitted" the report as "part of the record," but added that he would "not consider it." We disagree with the Referee's ruling.

Former OAR 438-05-07(3)(b) provided (in part):

> "Further supplemental exhibits may be submitted, provided they are accompanied by supplemental indexes meeting the above requirements. Further supplemental exhibits must be filed and provided to the other parties within seven (7) days of the submitting party's receipt of the exhibits."

Here, there is no contention that claimant failed to comply with the requirements of former OAR 438-05-07(3)(b). To the contrary,

the Referee recognized that the contested vocational report was "perfectly within" the Rule. While the insurer argued that the Rule did not "philosophically" cover vocational reports, it did not contend that claimant had failed to satisfy the procedural requirements of the Rule.

We find that former OAR 438-05-07(3)(b) did not distinguish between various types of documentary evidence. The Rule covered all "supplemental exhibits." Inasmuch as the contested vocational report was a supplemental exhibit, we conclude that claimant complied with the Rule.

Next, we examine whether the Referee had authority to "not consider" the contested vocational report. Despite the Referee's statement that he was "admitt[ing]" the report into the record, we interpret his refusal to consider the report as an exclusion of evidence. Authority for a referee to exclude evidence is found in OAR 438-05-07(8), which provides:

> "The referee may decline to receive in evidence either at or subsequent to the hearing, any medical or vocational report offered by a party who has refused to make the report available to the referee or other parties, or to permit examination thereof as required by the rule or the referee."

Here, claimant complied with former OAR 438-05-07(3)(b). There is nothing in the record that indicates claimant either refused to make the report available, or refused to permit examination thereof. Accordingly, we find that the Referee did not have authority to exclude the contested vocational report.

We may remand to the Hearings Division should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, we find that the Referee's exclusion of a properly submitted vocational report resulted in an incompletely developed record. Therefore, remand is appropriate.

Accordingly, this matter is remanded to the Hearings Division for consideration of the contested vocational report. The insurer shall be allowed either to present evidence in response to the vocational report or cross-examine the author of the vocational report.

ORDER

The Referee's order dated October 31, 1986 is vacated. This case is remanded to Referee Brown for further action consistent with this order.

KENNETH H. MacDONALD, Claimant
Scott M. McNutt, Claimant's Attorney
Foss, Whitty, et al., Defense Attorneys

WCB 85-16059
October 12, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that: (1) upheld the insurer's partial denial of claimant's duodenal peptic ulcer disease, peptic gastritis, gastric ulcer and psychological conditions; (2) finding these conditions noncompensable, upheld the insurer's denial of his aggravation claim; and (3) awarded an attorney fee for the insurer's late denial of his aggravation claim. The issues are compensability, aggravation, penalties and attorney fees.

We reverse that portion of the Referee's order that found claimant's psychological claim unrelated to his compensable injury. As a result, we also reverse that portion of the order that upheld the denial of the aggravation claim.

Claimant, 43 years of age at the time of hearing, was formerly employed as a deputy sheriff. In September 1984 he was conducting a raid on a marijuana field. The situation was stressful. Claimant experienced a sharp pain in his shoulder and quickly became disabled. Claimant was taken to the hospital by ambulance and diagnosed as having suffered an acute anterior wall myocardial infarction. Dr. Gross stated that the heart attack was due to a stress-induced spasm of the coronary artery. Arteriographic studies failed to relate the attack to atherosclerosis. The claim was accepted as a compensable injury. In April 1985 Dr. Gross stated that claimant had an essentially normal exercise tolerance for the performance of physical labor. He felt claimant had a small risk of suffering another myocardial infarction that was impossible to quantify.

In July 1985 Dr. Garcia, claimant's treating physician, declared claimant medically stationary and stated he could return to "non-mental stress work, i.e. physical work." In August 1985 claimant was examined by Dr. Holland, psychiatrist. Based on the medical evidence Dr. Holland concluded that claimant should not expose himself to situations that might produce additional spasms of the coronary arteries. Dr. Holland further stated that he could find no diagnosable mental disorder that precluded claimant from vocational activity or that required treatment. Noting that claimant was in need of stress management, Dr. Holland recommended effective vocational rehabilitation. He noted that claimant had submitted 102 resumes to various employers. Dr. Holland stated that a psychotherapist could be useful, but doubted claimant's personality structure would make such treatment effective. Quantifying the severity of various stressors on claimant, Dr. Holland rated the heart attack as extreme and his vocational status as severe.

In August 1985 a Determination Order awarded claimant 40 percent unscheduled permanent disability. In December 1985 a stipulation increased claimant's award to approximately 51 percent unscheduled permanent disability.

In December 1985, Dr. Garcia recommended that claimant undergo counseling. In March 1986 Dr. Fowler, internist,

diagnosed duodenal peptic ulcer disease. Subsequently, on March 10, 1986, claimant's attorney wrote the insurer requesting the claim be reopened for aggravation. Dr. Garcia referred claimant to Dr. Kirkpatrick, psychiatrist. In April 1986 Dr. Kirkpatrick diagnosed moderately severe posttraumatic stress disorder with depression and stress overtones. Dr. Kirkpatrick noted several incidents of stress besides the myocardial infarction that had contributed to claimant's condition. In May 1986 Dr. Garcia stated that claimant's condition had worsened secondary to emotional stress. He stated claimant's posttraumatic stress disorder was secondary to his police work.

In June 1986 Dr. Kirkpatrick reported that claimant's unresolved posttraumatic stress disorder was due to the heart attack and other prior incidents. He concluded that claimant's depression and posttraumatic stress disorder were fueled by unemployment and a sense of worthlessness. In August 1986 Dr. Kirkpatrick was deposed. Dr. Kirkpatrick outlined the events that had contributed to claimant's posttraumatic stress disorder and depression and recommended he not return to police or security work. Dr. Kirkpatrick stated that claimant's heart attack was a material contributing cause of his posttraumatic stress disorder. In September 1986 Dr.Garcia stated that claimant's posttraumatic stress disorder was a direct result of his heart attack. On September 18, 1986, the insurer denied claimant's posttraumatic stress disorder and gastric ulcer disease as unrelated to his myocardial infarction.

The Referee concluded that the doctine of res judicata barred claimant from raising his mental stress claim after the December 1985 stipulation. In addition, the Referee concluded that claimant failed to prove that his mental stress disorder was related to his myocardial infarction. We disagree.

Res judicata bars claims which were or could have been litigated in a prior proceeding. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980). Before applying res judicata, the second action must be the same cause of action as the first. Dean v. Exotic Veneers Inc., 271 Or 188 (1975). A cause of action is an aggregate of operative facts that compose a single occasion for judicial relief. Carr v. Allied Plating Co., 81 Or App 306 (1986). Here, the Referee concluded that Dr. Holland's August 1985 report constituted sufficient operative facts that claimant could have asserted a claim for the condition at the time of the December 1985 stipulation. However, Dr. Holland reported in his August 1985 report that claimant had no diagnosable mental disorder requiring treatment. It was not until April 1986, after the stipulation, that Dr. Kirkpatrick diagnosed posttraumatic stress disorder with depression and stress overtones. Inasmuch as claimant could not have filed a claim for a condition that had not yet been diagnosed, see Lawrence N. Sullivan, 39 Van Natta 88 (1987), we conclude that his current mental stress claim constitutes a new set of operative facts and is not barred by res judicata.

In addition, we are persuaded that claimant's heart attack was a material contributing cause of his psychological claim. Dr. Holland rated claimant's heart attack as a "severe" stressor. Drs. Kirkpatrick and Garcia stated that the heart attack was a material contributing cause of claimant's posttraumatic stress disorder and depression. Based on these medical opinions, we conclude that claimant has proved by a

preponderance of the evidence that his heart attack was a material contributing cause of his posttraumatic stress disorder and depression. See Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). Further, we are persuaded that claimant's mental stress disorder has resulted in increased disability and lessened his ability to work. See Smith v. SAIF, 302 Or 396 (1986). Consequently, claimant has proven that he suffered a compensable aggravation.

We modify the award of penalties and attorney fees.

We agree with the Referee that claimant was entitled to an attorney fee for the insurer's failure to respond to claimant's attorney's March 1986 request to reopen the claim. See Spivey v. SAIF, 79 Or App 568, 572 (1986). However, we further find that Dr. Kirkpatrick's April 1986 report is a separate claim for a mental disorder. See ORS 656.273(3). The insurer failed to issue its denial until September 18, 1986, well beyond the statutorily required 60 days. ORS 656.273(6); ORS 656.262(6). Consequently, we hold that the insurer's failure to timely respond to claimant's mental stress claim was unreasonable. Accordingly, we conclude that claimant is entitled to a penalty of 25 percent of any compensation due at the time of the September 18, 1986 denial. ORS 656.262(10). Furthermore, we find that $250 is a reasonable attorney fee for prevailing on this issue. id.

ORDER

The Referee's order dated November 6, 1986 is reversed in part, modified in part and affirmed in part. That portion of the order that upheld the insurer's denial insofar as it concerned claimant's current psychological problems is reversed. Furthermore, since claimant has also established an aggravation claim, the insurer shall process the claim until closure pursuant to ORS 656.268. Claimant is awarded a penalty of 25 percent of the compensation then due at the time of the September 18, 1986 denial and a $250 attorney fee for the insurer's untimely denial. For services rendered concerning the "psychological" and "aggravation" issues, claimant's attorney is awarded reasonable attorney fees of $1,200, for hearing, and $500, for Board review. These fees shall be paid by the insurer. The remainder of the Referee's order is affirmed.

OLEN E. MOYER, Claimant
Greg W. O'Neill, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-08612
October 12, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of claimant's claim for an alleged exposure to tuberculosis. The issue is whether claimant sustained a compensable injury resulting from a tuberculosis test required by SAIF's insured.

Following our de novo review of the record, we agree with the Referee that the claim is not compensable. Accordingly, we affirm the Referee's order.

Claimant has submitted a newspaper article which was not otherwise in the record. Such material is treated as a request for remand for the taking of additional evidence. Judy A Britton, 37 Van Natta 1262 (1985). The request is denied. After conducting our de

novo review, we find that the record has not been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(5).

Turning to the merits, we affirm the order of the Referee.

ORDER

The Referee's order dated February 19,1987 is affirmed.

KERRY G. PARMENTER, Claimant
Vick & Gutzler, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB TP-87013
October 12, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Claimant and the third party have agreed to settle claimant's cause of action for $4,000. The paying agency's lien is presently $6,665.72. Asserting that claimant's recovery would likely be greater if he proceeded to trial, the agency refuses to approve the current offer.

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 will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement amount appears to be grossly unreasonable. Steven B. Lubitz, 39 Van Natta 809 (September 24, 1987); Virginia Merrill, 35 Van Natta 251 (1983); Rose Hestkind, 35 Van Natta 250 (1983).

Applying the aforementioned standard to the present record, we are not persuaded that the settlement offer is grossly unreasonable. Consequently, the settlement offer of $4,000 is approved. Furthermore, the proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

GRACE L. STEPHEN, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-14678
October 12, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee St. Martin's Order on Reconsideration that: (1) granted claimant permanent total disability; (2) awarded three months of temporary disability following a 1962 surgery and three months of temporary disability following a 1971 surgery; and (3) declined to allow SAIF to offset temporary disability paid following a prior Referee's order. The issues are permanent total disability, temporary total disability and offset.

Claimant worked as a welder for SAIF's insured from 1942 until 1945. During that period, she had significant exposure to asbestos. Since leaving work in 1945, claimant has neither sought nor obtained work other than raising her large family. Ultimately, claimant developed squamous cell carcinoma that resulted in a 1962 left vocal cord excision and a 1971 total laryngectomy. In August 1982 claimant filed a claim for her cancer based on asbestos exposure. A May 1984 Referee's order

found claimant's condition compensable. The Referee's order was affirmed by the Board in December 1984. Grace Stephen, 36 Van Natta 1881 (1984). In August 1985 a Determination Order issued awarding claimant 100 percent unscheduled permanent disability, but no temporary total disability. At hearing claimant sought permanent total disability and temporary disability compensation.

We reverse that portion of the order that allowed claimant temporary total disability following the 1962 and 1971 surgeries.

The Referee concluded that claimant was totally disabled for the three months following each of the aforementioned surgeries. As a result, the Referee awarded temporary disability for those two periods. On appeal, SAIF asserts that claimant was a retired worker within the meaning of Cutright v. Weyerhaeuser Co., 299 Or 290 (1985) and, therefore, not entitled to temporary total disability. We agree.

A worker who voluntarily leaves the labor market is not entitled to temporary total disability. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). Here, following claimant's 1945 departure from work, she neither sought nor obtained work outside of her home again. Consequently, we conclude that she is not entitled to temporary total disability.

We affirm the Referee's finding of permanent total disability with the following comment.

SAIF does not contest that claimant's compensable occupational disease and its residuals have resulted in her being incapacitated from performing work at a gainful and suitable occupation. Further, despite being a retired worker, the evidence supports the conclusion that any attempt by claimant to locate work would have been futile. See Butcher v. SAIF, 45 Or App 146 (1983). As a result, we find that claimant has satisfied the seek work requirement of ORS 656.206(3).

SAIF asserts that claimant's status as a retired worker, within the meaning of Cutright, precludes her from receiving an award of either permanent partial disability or permanent total disability. We disagree and conclude that the principles underlying Cutright, are not applicable to awards of either permanent partial disability or permanent total disability.

In Everett S. Standley, 39 Van Natta 486 (1987), we concluded that Cutright was specific in its discussion of the effect of retirement on temporary total disability benefits. We, therefore, found its holding limited to that benefit. In addition, we found that the principles underlying temporary total disability were fundamentally different from those involving unscheduled permanent disability, i.e. lost wages versus lost earning capacity. Consequently, we held that Cutright did not apply when awarding permanent partial disability. We continue to adhere to that holding.

Analytically, the application of Cutright to awards of permanent total disability is a closer legal question. However, based on the reasoning expressed in Standley, we find the purposes underlying the payment of permanent total disability and temporary total disability to be significantly different. Consequently, we conclude that the Cutright holding applies only to temporary total disability and does not preclude the award of permanent total disability.

Finally, we reverse that portion of the order that declined to grant SAIF permission to offset temporary disability paid following the prior Referee's order.

Following the prior Referee's May 1984 order, SAIF paid claimant temporary total disability totaling $40,922.02. A November 1985 Determination Order awarded 100 percent unscheduled permanent disability, but no temporary disability. SAIF was permitted to offset the payment of permanent disability against the temporary total disability. A balance of overpaid temporary total disability of $18,522.02 remained. At hearing, SAIF sought to offset the remaining balance of overpaid temporary disability against claimant's award of permanent total disability. The Referee relied on ORS 656.313(2) and declined to authorize the offset. We disagree.

The filing of a request for review or court appeal by an employer/insurer does not stay the payment of compensation to claimant. ORS 656.313(1). Further, ORS 656.313(2) states: "If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal." (emphasis added).

Here, temporary disability compensation was paid following the prior Referee's May 1984 finding of compensability. This compensability finding was affirmed on appeal. Yet, upon claim closure, the Determination Order awarded no temporary disability. At hearing, the present Referee acknowledged that claimant was not entitled to the temporary disability paid following the prior Referee's order. Inasmuch as the reduction of temporary disability was initiated by the Determination Order and approved on appeal, the reduction in temporary disability was not due to a Board or court order. Consequently, ORS 656.313(2) does not apply. Accordingly, SAIF is allowed to offset temporary disability paid following the prior Referee's May 1984 order.

ORDER

The Referee's Order on Reconsideration dated September 26, 1986 is affirmed in part and reversed in part. That portion of the order that awarded temporary total disability following the 1962 and 1971 surgeries is reversed. That portion of the order that declined to allow SAIF to offset overpaid temporary disability paid prior to the August 1985 Determination Order against claimant's permanent total disability award is reversed. SAIF is authorized to offset the payment against the award of permanent total disability. The remainder of the order is affirmed. Claimant's attorney is awarded $550 for services on Board review concerning the permanent total disability issue, to be paid by the SAIF Corporation.

VIRGIL M. ECKSTEIN, Claimant
William B Wyllie, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-10546
October 13, 1987
Order of Dismissal

Claimant has requested review of the Referee's order dated September 2, 1987. Claimant's request, dated September 30, 1987, was mailed on October 3, 1987. The Board received the request on October 5, 1987. Neither an acknowledgement of service upon the self-insured employer nor a certificate of personal service by mail was provided with the request.

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

Here, claimant's request for Board review was dated within 30 days of the Referee's order. However, the request was not mailed to the Board within 30 days of the Referee's order. Furthermore, the record fails to establish that the employer was either provided a copy, or received actual knowledge, of the request within the statutory 30-day period. Consequently, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

CHARLEY JACKMAN, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-04385
October 13, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of those portions of Referee Leahy's order that: (1) set aside its denial of diagnostic medical services relating to claimant's low back; (2) rejected its request for authorization to offset interim compensation paid in connection with claimant's aggravation claim against future compensation; (3) rejected its request for authorization to offset, against future compensation, unemployment compensation received by claimant during the period in which he was receiving interim compensation; and (4) awarded claimant's attorney an attorney fee of $1,200 in connection with the above issues. Claimant cross-requests review of those portions of the order that: (1) found that the claim had not been prematurely closed; (2) upheld the insurer's denial of an aggravation claim relating to his left leg; (3) upheld the insurer's partial denial relating to his low back; (4) granted claimant no award of permanent partial disability for his left leg or low back; (5) awarded his attorney an attorney fee of $1,200; and (6) rejected his request for penalties and attorney fees in connection with the medical services denial on the ground that the denial was unreasonable. The issues are medical services, offset, compensability, premature closure, aggravation, extent of disability, penalties and attorney fees.

The Board affirms the order of the Referee with the exception of that portion of the order that refused to grant the insurer authorization to offset, against future compensation, unemployment compensation received by claimant during the period in which he was receiving interim compensation. After the date of the Referee's order, the Court of Appeals expressly recognized the propriety of such offsets in Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987).

ORDER

The Referee's order dated November 14, 1986 is affirmed in part and reversed in part. That portion of the order that refused to authorize an offset, against future compensation relative to this claim, of unemployment compensation received during the period in which claimant was receiving interim compensation is reversed. Such authorization is granted. The remainder of the order is affirmed. Claimant's attorney is awarded $400 for services on Board review on the medical services issue, to be paid by the insurer.

SANDRA M. JONES, Claimant
Richard Adams, Claimant's Attorney
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-07947 & 85-09680
October 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

United Grocers Insurance Company requests review of Referee Mongrain's order that set aside its denial of claimant's aggravation claim relating to her low back. The issue is responsibility.

Claimant injured her low back in March 1984 in the course of her employment as a grocery clerk when she lifted a case of beer. United Grocers was the insurer. Her symptoms were low back pain radiating into her right leg to the foot. A herniated L5-S1 disc was diagnosed by Dr. Sutherland, a neurosurgeon, and he performed surgery in April 1984 to remove the herniated disc material. About a month after the surgery, Dr. Sutherland reported that claimant's back and leg pain were improved, but that she sometimes experienced a tingling sensation in her foot. Later reports indicated that these symptoms continued and there is also some mention of pain or tingling in her left leg, although it was less severe.

Claimant returned to work for another employer in January 1985 as a waitress. The SAIF Corporation was the insurer of the new employer. Claimant worked until early April 1985 when she experienced a severe increase in low back and bilateral leg pain at the end of a shift. No particular incident or accident coincided with the increase in pain. During the months of her work as a waitress, claimant had experienced a gradual increase in low back pain which she associated with her employment. A recurrent disc herniation at L5-S1 was diagnosed and Dr. Sutherland performed another surgery. The surgery confirmed the extrusion of more nuclear material from the disc.

In order to shift responsibility for claimant's low back condition from itself to SAIF, United Grocers has the burden of proving that claimant's work as a waitress independently contributed to a worsening of her underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986); Eva L. (Doner) Staley, 38 Van Natta 1280, 1281 (1986).

Two physicians gave opinions relating to this question, Dr. Sutherland, and Dr. Tennyson, a consulting neurosurgeon who testified at the hearing. In May 1985, Dr. Sutherland stated: "[T]he employment as a waitress . . . contributed to [her] need for surgery due to an aggravation of back and leg pain. . . . [T]he work appeared to have contributed to an exacerbation of symptoms." When asked to clarify his opinion, Dr. Sutherland stated:

> "The employment [as a waitress] did contribute slightly to her present disability, as the job was of such a type, that of waitressing, that she remained on her feet a good deal of the time, while carrying trays, etc. As a result, this caused her to aggravate the pain in the lower back and right lower extremity. As a result, the subsequent treatment and operative intervention was found to be necessary."

Based upon his review of the case, Dr. Tennyson testified that the reherniation of claimant's disc occurred anywhere from a few hours to a few days prior to the time that she left work in April 1985. He named four factors which contributed to the reherniation of the disc: (1) the natural degeneration of the disc; (2) an incision of the disc during the prior surgery; (3) activities of daily living; and (4) claimant's work as a waitress. He defined "activities of daily living" as those activities in which claimant engaged while not working. When asked to rate the relative contribution of these factors, Dr. Tennyson stated with regard to the last two factors that he was unable to separate the contributions of daily living activities and claimant's employment as a waitress because he did not have enough information about her daily living activities. He stated, however, that together the last two factors were 15 percent responsible for the reherniation. Claimant had testified that she lived in a rented apartment during her employment as a waitress and that her work was more strenuous than her off-the-job activities. She was not questioned regarding the specifics of these activities, however.

On this record, the Referee concluded that claimant's work as a waitress had not independently contributed "in more than a de minimis way" to a worsening of her underlying condition and concluded that United Grocers, the first insurer, remained responsible. We reverse.

Claimant's disc reherniated a short time before she left work in April 1985. This clearly constituted a worsening of the underlying condition. The question is whether claimant's work for three months as a waitress contributed independently to this worsening. Dr. Sutherland's opinion is unclear on this point. On one hand, he appears to say that claimant's work as a waitress contributed to a worsening of her symptoms, but not necessarily to the worsening of the underlying condition. On the other hand, he states that claimant's employment as a waitress "contribute[d] slightly to her present disability" and that surgery for the reherniated disc would not have been necessary but for that employment. This ambiguity is explained in part by the fact that the opinion was requested and rendered before the legal standard in responsibility cases was clarified in Hensel Phelps Construction v. Mirich, supra.

Dr. Tennyson's opinion, by contrast, is relatively clear. He thought that claimant's employment as a waitress along with her daily living activities had contributed 15 percent to the reherniation of her disc. Given claimant's testimony that her work activity was more strenuous than her activities of daily living, we find that most of this contribution was due to her employment. We conclude, therefore, that claimant's work for SAIF's insured independently contributed to a worsening of her underlying condition and that SAIF is responsible for that condition.

ORDER

The Referee's order dated January 22, 1987 is reversed. The denial issued by United Grocers Insurance Company and dated June 20, 1985 is reinstated and affirmed. The denial issued by the SAIF Corporation and dated July 3, 1985 is set aside and the claim is remanded to SAIF for processing according to law. SAIF shall reimburse United Grocers for its claim costs to date, as well as pay claimant's attorney the attorney fee awarded by the Referee.

EDWARD J. KELLY, Claimant
Galton, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-03841
October 13, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Neal's order that: (1) set aside its denial of an aggravation claim relating to claimant's low back; (2) set aside its denial of authorization for surgery relating to claimant's low back; and (3) refused to rate the extent of claimant's low back disability. Claimant cross-requests review of those portions of the order that: (1) refused to readjust his temporary disability rate; and (2) rejected his request for penalties and attorney fees for an allegedly improper adjustment of his temporary disability rate. The issues are aggravation, medical services, extent of disability, temporary disability compensation, penalties and attorney fees.

The Board affirms the order of the Referee with the exception of that portion of the order that set aside the insurer's denial of authorization for surgery.

Claimant compensably injured his back in February 1984 when he lifted a number of heavy auto parts. The injury was treated conservatively and the claim was closed by Determination Order in November 1984 with no award of permanent disability.

Claimant experienced an increase in low back pain in mid-1985 and began treating with Dr. Neitling, an orthopedic surgeon. Dr. Neitling prescribed a course of physical therapy and the insurer reopened the claim on an aggravation basis. In October 1985, claimant underwent a CT scan which showed no disc abnormalities. The consulting radiologist, however, did comment about an apparent partial sacralization of L5. A short time later, Dr. Neitling reviewed the CT scan and opined that the partial sacralization as aggravated by the industrial injury was probably the primary cause of claimant's ongoing low back discomfort.

An independent medical examination was performed by the Orthopaedic Consultants in January 1986. They found little objective evidence of impairment other than some tenderness in the right sacroiliac joint and some loss of sensation in the right foot. They recommended claim closure. Dr. Klein, a psychiatrist, also examined claimant and diagnosed a personality disorder of mixed type with passive-aggressive, hypochondriacal and hysteroid features. She did not think, however, that this disorder had been affected by the industrial injury. The claim was closed by Determination Order in March 1986 with no award of permanent disability.

In June 1986, claimant experienced a marked increase in low back pain after performing some yardwork at home. He returned to Dr. Neitling and physical therapy was resumed. The following month, Dr. Neitling indicated that claimant's condition had returned to its preexacerbation level, but recommended another month of physical therapy.

About a week later, claimant was examined by Dr. Berkeley, a neurosurgeon, on referral from his attorney, and underwent an MRI scan. The scan was interpreted by the attending radiologist as showing bulging discs and mild to moderate spinal stenosis at L3-4, L4-5 and L5-S1. Dr. Berkeley then wrote the insurer with a request for authorization to perform surgery at L4-5.

The insurer asked Dr. Neitling to comment on the need for surgery, but he deferred to Dr. Berkeley. Claimant was then reexamined by the Orthopaedic Consultants. They found no clinical evidence of a significant disc herniation or spinal stenosis. They also reviewed the MRI scan and commented: "We do not concur with the impression on [sic] spinal stenosis of significant degree. We agree that there may be slight disc bulging but no significant disc herniation. There is a Schmorl's node. Nothing on the MRI would to us indicate the need for surgery." The insurer issued a denial of the surgery proposed by Dr. Berkeley on the ground that it was not reasonable and necessary.

A short time later, Dr. Berkeley reasserted claimant's need for surgery in a letter to the insurer. He stated that claimant's spinal stenosis probably predated his industrial injury, but that it had become symptomatic at the time of the injury and had progressively worsened ever since.

At the hearing, claimant testified that he had returned to work about a month and a half previously as an acoustical ceiling tile installer. The work involved driving a truck, unloading boxes of acoustical tile, lifting the tiles onto scaffolds and then placing the tiles into prehung metal frames. During this process, claimant regularly lifted objects weighing between 30 and 40 pounds. He reported some increase in back pain since starting this job, but had not missed any work as a result.

On the question of the authorization for surgery, the Referee accepted the opinion of Dr. Berkeley and set aside the insurer's denial. The Referee acknowledged the contrary opinion of the Orthopaedic Consultants, but found it less persuasive on the ground that it was not well-explained.

After our de novo review of the evidence, we conclude that, at best, it is in equipoise. Dr. Berkeley thought that the spinal stenosis was significant enough to warrant surgery. The Orthopaedic

Consultants did not. Dr. Berkeley first examined claimant late in the life of the claim and his opinion is not due the added deference owing that of a treating doctor from the claim's inception. We find the basis of the opinion by the Orthopaedic Consultants to be at least as well-explained as that of Dr. Berkeley. In addition, as of the date of the hearing, claimant was successfully performing regular work in the medium category. Under these circumstances, we conclude that claimant has failed to carry his burden of proving that the proposed surgery is reasonable and necessary.

ORDER

The Referee's order dated November 28, 1986 is reversed in part. That portion of the order that set aside that portion of the insurer's denial dated September 26, 1986 relating to the surgery proposed by Dr. Berkeley is reinstated and affirmed. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services on Board review in connection with the aggravation issue, to be paid by the insurer.

LAVERNE L. MANSELLE, Claimant
Jolles, Sokol, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 84-03015
October 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of those portions of Referee Leahy's order that: (1) set aside its denial of claimant's aggravation claim relating to his low back; (2) increased claimant's award of unscheduled permanent partial disability for his low back from the 20 percent (64 degrees) previously granted to 55 percent (176 degrees); (3) set aside its denial of pain center treatment; and (4) directed it to pay claimant temporary disability compensation during pain center treatment and a work hardening program. The issues are aggravation, extent of disability, medical services and temporary disability compensation.

Claimant injured his low back in November 1981 in the course of his employment as a heavy equipment operator when he lifted a heavy piece of cast iron pipe. Claimant had previously injured his low back in an industrial accident in 1968 and had undergone laminectomies at L4-5 and L5-S1 in 1969. That claim was closed without an award of permanent partial disability. The 1981 injury was diagnosed as a lumbar strain with radiation into the right leg to the foot and was treated conservatively. Claimant was released to return to work about two weeks after the accident and the claim was apparently closed by Notice of Claim Closure.

Claimant continued to work until April 1983, when he sought treatment from Dr. Miller, a neurosurgeon, with complaints of increasing low back and right leg pain. A myelogram revealed a herniated L5-S1 disc and a laminectomy at that level was carried out by Dr. Miller in July 1983. Claimant recovered steadily after the surgery and his leg pain diminished. Dr. Miller declared him medically stationary in late January 1984 and recommended that he not return to work which required repetitive bending at the waist or repetitive lifting over 25 pounds. He did not provide an express impairment rating, however. The claim was closed by Determination Order in March 1984 with a 20 percent unscheduled award.

During the year following claim closure, claimant participated in an authorized training program in commercial art. In

February 1985, he complained to Dr. Miller of increased low back pain which claimant attributed to prolonged sitting and standing associated with his classes. Dr. Miller prescribed a back brace and claimant continued his schooling. After claimant completed the schooling and received his degree, another Determination Order issued in July 1985 which reevaluated his prior permanent disability award and determined that no change in the award was warranted.

Two and a half weeks later, Dr. Miller referred claimant to Dr. Salumbides, a neurosurgeon, for evaluation of claimant's ongoing back complaints. Dr. Salumbides recorded a positive straight leg raising test, but otherwise noted nothing different from previous examinations. He recommended continued conservative treatment. Claimant retained an attorney a few days later and the attorney filed an aggravation claim, which was denied by the insurer.

About the same time, claimant began treating with Dr. Edwards, an internist. He recommended that claimant be enrolled in a pain center. He later indicated, however, that claimant's condition had not worsened since the last claim closure. The pain center staff (including a psychologist) subsequently examined claimant and they also recommended admission. These recommendations were echoed by Dr. Raaf, a neurosurgeon, after an independent medical examination in October 1985. During that examination, claimant told Dr. Raaf that his back condition had remained relatively constant since he began his schooling in early 1984. Given this history, Dr. Raaf opined that claimant was medically stationary and rated the impairment due to the 1981 industrial accident as mildly moderate. Claimant began treating with Dr. Raaf at that time. The insurer never issued a formal denial of pain center treatment, but did verbally deny authorization for the treatment.

Between November 1985 and March 1986, claimant participated in an on-the-job training program with a small graphic arts business. After the completion of the program, the business did not have any openings and was unable to hire claimant. Claimant then began looking for commercial art positions elsewhere, but as of the time of the hearing, was not employed. A third Determination Order issued in March 1986 which reevaluated claimant's previous permanent disability award and determined that no change was warranted. A couple of weeks later, claimant began a work hardening program on the recommendation of Dr. Raaf which lasted for seven weeks. In April 1986, Dr. Salumbides was deposed on the aggravation question. He opined that claimant's condition had not worsened and expressly downplayed the significance of the positive straight leg raising test, saying that the test may fluctuate in a single individual without any indication of a change in condition.

The hearing occurred in late June 1986. Claimant testified that his back pain worsened just prior to his visit with Dr. Salumbides in July 1985.

The Referee set aside the insurer's aggravation denial on the apparent ground that the presence of a positive straight leg raising test as noted by Dr. Salumbides in combination with claimant's testimony that his back pain increased about that time constituted sufficient proof of a worsening of claimant's condition. This conclusion, however, is contrary to the weight of the medical evidence. All of the doctors who examined claimant stated that claimant's condition did not worsen during the relevant period. Claimant also indicated at that time that his condition had not worsened. Dr. Salumbides testified that the positive straight leg raising finding did not necessarily, or even probably, indicate a

worsening of claimant's condition. On this record, we conclude that claimant has failed to establish a compensable worsening of his condition.

The Referee also set aside the denial of pain center treatment. This action is overwhelmingly supported by the record and shall be affirmed. In light of the Board's reinstatement of the aggravation denial, however, no temporary disability compensation is due and claimant is not entitled to temporary disability compensation during his participation in work hardening or pain center programs.

On the issue of extent of disability, the Referee increased claimant's award from 20 to 55 percent. We find that claimant's disability exceeds that reflected by the Determination Orders, but conclude that the award granted by the Referee was excessive.

In rating the extent of unscheduled disability for claimant's low back, we consider his physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 40 years old at the time of the hearing, is a high school graduate and has an associates degree in commercial art. His work experience is mainly in the areas of heavy equipment operation and construction. Following our de novo review of the medical and lay evidence, we conclude that claimant's low back impairment is in the mildly moderate category. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 112 degrees for 35 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury.

ORDER

The Referee's order dated November 6, 1986 is affirmed in part, modified in part and reversed in part. Those portions of the order that set aside the insurer's aggravation denial dated September 19, 1985, directed the insurer to pay temporary disability compensation during work hardening and pain center programs, and that awarded claimant's attorney an insurer-paid attorney fee of $1,000 are reversed. In lieu of the award of permanent disability granted by the Referee, claimant is awarded 15 percent (48 degrees) unscheduled permanent partial disability for his low back in addition to the 20 percent (64 degrees) previously granted for a total of 35 percent (112 degrees). Claimant's attorney's fee shall be adjusted accordingly. The remainder of the order is affirmed.

HOLLY A. STRONG (COFFMAN), Claimant
Joel Lieberman, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-07064
October 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Podnar's order that: (1) found claimant's low back injury claim untimely; and, in the alternative, (2) upheld the SAIF Corporation's denial of compensability and/or responsibility for the aforementioned condition. The issues are timeliness, compensability, and responsibility.

We affirm the order of the Referee with the following comment concerning the timeliness issue.

Following our de novo review of the medical and lay evidence, we are not persuaded that SAIF's insured had knowledge of an "injury" suffered by claimant that was possibly attributable to her work activities. See ORS 656.265(4)(a); Hayes-Godt v. Scott Wetzel Services, 71 Or App 175, 179 (1984). Furthermore, the record suggests that SAIF has been prejudiced by its failure to receive timely notice of the allegedly injurious accident. See ORS 656.265(4)(a); Vandre v. Weyerhaueser, 42 Or App 705 (1979). Finally, the evidence fails to establish "good cause" for claimant's failure to file her claim until approximately 11 months after the allegedly injurious accident. See ORS 656.265(4)(c). Accordingly, we agree with the Referee that claimant's injury claim should be barred as untimely filed.

Having concluded that the claim was untimely filed, we need not address the issue of compensability.

ORDER

The Referee's order dated February 19, 1987 is affirmed.

JOHN W. BENNINGER, Claimant
Steven C. Yates, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-12595
October 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Quillinan's order that set aside its partial denial relating to claimant's spondylolisthesis condition and awarded claimant's attorney an attorney fee of $1,100. The issues are compensability, medical services and attorney fees.

The Referee concluded that claimant's spondylolisthesis condition was compensable on the ground that the industrial injury made a previously asymptomatic condition symptomatic. After our de novo review of the record, we find that claimant's condition was in fact symptomatic from an off-the-job injury at the time of the industrial injury. We further find that the underlying condition was not worsened by the industrial injury and thus conclude the employer is not responsible for the treatment of that underlying condition. We, therefore, reverse the Referee's order and reinstate the employer's partial denial. Given our conclusion on the compensability issue, the medical services and attorney fee issues are moot.

ORDER

The Referee's order dated January 5, 1987 is reversed.

MYRON E. BLAKE, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Legal (Salem), Defense Attorney

WCB 85-05348 & 85-08114
October 16, 1987
Order Dismissing Request for Review and Remanding

Reviewed by Board Members McMurdo and Lewis.

We have interpreted claimant's September 28, 1987 letter as a request for review of Referee Podnar's September 23, 1987 order. The request has been reviewed to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither finally denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's order neither finally disposed of nor allowed the claim. Rather, the order responded to what the Referee considered to be the Board's instructions in its March 25, 1987 Order on Review (Remanding). See Myron E. Blake, 39 Van Natta 144 (1987). Pursuant to our prior order, this case was remanded for the taking of additional evidence. Specifically, we concluded that EBI Companies was entitled to conduct an independent medical examination.

The Referee apparently assumed that the Board's remand order was interim in nature, thereby enabling it to retain jurisdiction over the remaining issues raised in the prior Referee's April 10, 1986 order. Such an assumption would be inaccurate, inasmuch as the prior Referee's order was vacated. Furthermore, since the Board remanded the case for further proceedings consistent with its order, the Referee was implicitly directed to address the issues raised in the prior proceeding in light of the additional evidence.

Because the Referee's order fails to resolve the aforementioned issues, we find that further action before the Hearings Division is required. Consequently, we conclude that the Referee's order is not a final appealable order and that we lack jurisdiction to consider this matter. See Price v. SAIF, supra; Lindamood v. SAIF, supra.

Accordingly, the request for Board review is dismissed. This case is remanded to Referee Podnar for further action consistent with this order, as well as our March 25, 1987 order.

IT IS SO ORDERED.

RONALD D. CHAFFEE, Claimant
Harper, Leo & Hollander, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-03983
October 16, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of that portion of Referee Fink's order that affirmed an order issued by the Evaluation Division which set aside its notice of claim closure as premature. Claimant cross-requests review of those portions of the order that upheld the insurer's partial denials relating to his ongoing course of chiropractic treatment and his psychological condition. The issues are the compensability of claimant's psychological condition, premature closure and medical services. Claimant has filed no brief on Board review.

Claimant injured his low back in December 1983 in the course of his employment as an auto mechanic when he pulled a heavy tire and wheel off a truck. After the injury, claimant was treated by Dr. Berovic, a chiropractor, at a rate of three times per week for the first month and then twice per week through the date of the hearing in February 1986.

In February 1985, more than a year after the industrial accident, claimant was examined by a consulting chiropractor, Dr. King. Dr. King noted muscle spasms in claimant's low back and recorded positive responses to a number of named orthopedic and neurological tests. He also noted complaints of severe pain. In commenting on claimant's condition, Dr. King stated: "With the duration of his present symptoms, I would assume that it is not going to be in the near future that [claimant] is able to return to work or become medically stationary." He suggested a neurological consultation and a CT scan.

The following month, claimant was examined by another consulting chiropractor, Dr. Gatterman. In her report, Dr. Gatterman indicated that claimant was hostile and noncooperative during the examination. She found claimant medically stationary and stated that there was no objective evidence of impairment as a result of the December 1983 injury. She also stated that there was no need for ongoing chiropractic care. A few days later, the insurer issued a denial in which it stated:

> "We are partially denying your claim. We have paid all the mileage to and from Dr. Berovic's office, however, we are not paying all the medical bills. The treatment is excessive in our opinion. We are paying for two visits per month."

Claimant requested a hearing.

In April 1985, Dr. Berovic voiced his disagreement with those portions of Dr. Gatterman's report that recommended curtailment of chiropractic treatment and that found no evidence of permanent impairment. The following month, claimant began receiving vocational assistance in the form of a direct employment program. Within a few weeks, a position as a light duty mechanic and service station attendant was located and a wage subsidy agreement was drawn up and signed by claimant. The agreement stated that claimant was to begin work on June 3, 1985.

Dr. Berovic reviewed a job analysis of the position and approved it as within claimant's physical capacities. He refused to release claimant for work, however, with the comment, "The carrier is refusing to authorize treatment. [Claimant] will not be released until adequate treatment is authorized." Claimant did not appear for work on the appointed day and, on June 11, 1985, his vocational file was closed under OAR 436-61-126(10) (since amended and renumbered OAR 436-120-090(6)) for failure to accept an offer of suitable employment.

In early June 1985, Dr. Berovic referred claimant for examination by another chiropractor, Dr. Bussanich. In a report dated June 10, 1985, Dr. Bussanich noted positive responses to a number of named orthopedic and neurological tests as well as limitations in spinal ranges of motion. His diagnoses included thoracic, lumbar and sacroiliac strains. With regard to claimant's course of treatment with Dr. Berovic, he commented that such treatment would not provide any further curative benefit, but that it would provide "short-term significant symptomatic relief."

In July 1985, claimant was examined by a consulting orthopedic surgeon, Dr. Duff. Dr. Duff found no objective evidence of impairment that he could relate to the industrial injury. Regarding claimant's ongoing chiropractic treatment, he stated:

> "I do not feel that after eighteen months of treatment one can realistically expect any further improvement here, and he is from that point of view medically stationary. He seems to gain considerable, if temporary, symptomatic relief from his chiropractic treatments. I can see no exceptional condition here that would merit a greater frequency of treatment than that allowed under the Workers' Compensation Guidelines, which I believe allow for one or two 'maintenance' treatments per month."

A few days later, claimant was examined by an osteopath, Dr. Nelson. Dr. Nelson found little objective evidence of pathology, but recommended a CT scan to rule out the possibility of a herniated disc or spinal stenosis. The CT scan was carried out on July 23, 1985 and revealed nothing outside normal limits, except a bulging disc at L4-5. This procedure was followed by a myelogram on August 7, 1985 which revealed no evidence of a herniated disc. Possible congenital spinal canal stenosis was noted, however.

On November 18, 1985, Dr. Berovic reported that he had reviewed Dr. Duff's report. He disagreed with Dr. Duff's conclusions that claimant had sustained no permanent impairment and that his condition did not require more than two chiropractic treatments per month. He did not comment concerning Dr. Duff's conclusion that claimant was medically stationary.

On November 19, 1985, Dr. Voiss, a psychiatrist, issued a report of a psychological evaluation conducted in late September 1985. In the report, Dr. Voiss reviewed claimant's medical history prior to the December 1983 industrial accident, which included two industrial low back injuries and various somatic complaints spanning more than a decade. Dr. Voiss then commented on the results of an MMPI which he interpreted as showing chronic

psychopathology as reflected in feelings of inadequacy, inferiority and insecurity. His ultimate diagnoses were borderline personality disorder and psychogenic pain disorder. Regarding the cause of claimant's psychological condition, he opined:

> "[Claimant] is a young man who suffers from significant long-standing psychological difficulties. These troubles have been repeatedly communicated through his use of the somatic metaphor as noted in the clinical records and psychological testing. These difficulties are not in any way etiologically related to the multiple described industrial injuries or the relatively recent event of December 1983 except that the events outside of himself will be used as focal retrospective rationalizations of his inadequacies."

Later in the report, he added that claimant's December 1983 industrial injury "should be viewed as psychologically 'enabling' and not 'disabling.'"

On November 20, 1985, Dr. Voiss conducted a "psychokinetic" evaluation of claimant. The purpose of this evaluation, as explained by Dr. Voiss in testimony at the hearing, was to test the muscle strength and range of motion of claimant's lower extremities and then to analyze these tests for internal consistency. Claimant's legs were strapped into a machine which was connected to a computer and he was then instructed to perform various movements at varying speeds. After conducting this examination and analyzing the results, Dr. Voiss reported:

> "The findings of this evaluation clearly document the intentional (unconscious) though not necessarily deliberate (conscious) effort to present as disabled and unable to perform. If the findings of this evaluation accurately portrayed claimant's lower extremity capacity, he would not be able to walk. There is no objective evidence of organic impairment on analysis of this evaluation."

In a deposition taken on November 22, 1985, Dr. Bussanich stated that he recommended against any surgery on claimant's back because he did not think it would improve claimant's condition. The same day, the insurer issued a partial denial relating to the psychological conditions identified in the report by Dr. Voiss. The denial read:

> "Our on-going medical investigation shows that you are experiencing symptoms related to a psychological condition. We are hereby denying any psychological condition as not related to your condition. This is a partial denial only."

Claimant filed a supplementary request for hearing on this denial.

On November 25, 1985, the insurer issued a notice of claim closure pursuant to ORS 656.268(3). Claimant requested that the Evaluation Division review the notice. On November 26, 1985, Dr. Duff issued a short report in which he indicated that he agreed with the conclusions stated in the November 19, 1985 report by Dr. Voiss.

Some time prior to December 16, 1985, Dr. Berovic issued an undated form letter referring claimant to Dr. Smith, a neurosurgeon, for a "comprehensive consultation" including "a recommendation or verification of treatment and prognosis" and the rating of permanent impairment, if any. On January 8, 1986, the Evaluation Division issued an order setting aside the insurer's notice of claim closure as premature. The insurer filed a cross-request for hearing on this issue.

Dr. Smith issued a report of his examination on January 9, 1986. He reported little or no objective evidence of pathology, but recommended an EMG involving the lower extremities and a pain center evaluation. The EMG was conducted a few days later and was normal.

Later the same month, Dr. Berovic reported that he had reviewed the report by Dr. Voiss and that he disagreed with the conclusion that claimant's problems were "purely mental in nature." Dr. Berovic reported positive responses to a number of named orthopedic and neurological tests and range of motion limitations. A few days later, Dr. Berovic referred claimant for magnetic resonance imaging. This procedure confirmed a four millimeter central bulge of the L4-5 disc, but otherwise was unremarkable.

On February 18, 1986, Dr. Smith reported that he had reviewed the reports by Dr. Voiss and Dr. Duff. He expressed no basic disagreement with them, but renewed his recommendation that claimant be evaluated at a pain center.

The case came to hearing before Referee Fink on February 28, 1986. At the beginning of the hearing, counsel for the insurer stated that the insurer was proceeding on the theory that the denial of claimant's psychological condition was a denial of future responsibility for all symptoms related to claimant's low back. According to this theory, claimant's compensable physical injury had resolved without permanent impairment and claimant's ongoing symptomatology was the result of his psychological condition which, allegedly, was not compensably related to the resolved physical injury.

In his testimony, claimant indicated that he experienced a constant dull ache in his low back with occasional knife-like pains. He stated that he had good days and bad days depending on his activity level and that he continued to treat twice per week with Dr. Berovic. He testified that the treatments provided significant relief from his low back pain lasting up to a few days. The Referee found claimant of questionable credibility based upon his observation of claimant's demeanor.

An employee of the Evaluation Division testified concerning his reasons for setting aside the insurer's notice of claim closure. He stated that the information which he received from the insurer did not indicate that claimant was medically stationary. The presence of the bulging disc at L4-5 and Dr. Berovic's form letter referring claimant to Dr. Smith were

identified as key pieces of information in the employee's decision. The employee indicated that he was aware of claimant's psychological condition, but did not indicate that it played any role in his decision to set aside the notice of closure.

Dr. Simpson, a chiropractor, also testified. He had never examined claimant, but was called to comment on information contained in Dr. Berovic's reports. He very effectively critiqued Dr. Berovic's report of positive orthopedic and neurological findings. He discussed the nature of each of the tests mentioned by Dr. Berovic and stated that the summary manner in which the tests and findings were described rendered the findings virtually worthless.

Dr. Voiss, the examining psychiatrist, also testified. He held to his previous opinion that claimant's low back symptoms had no connection to the industrial injury and were merely coincidental with it.

The Referee issued his Opinion and Order in August 1986. He affirmed the Evaluation Division's order setting aside the insurer's notice of claim closure as premature, upheld the medical services denial limiting chiropractic treatment to twice per month and upheld the partial denial of claimant's psychological condition to the extent that it denied the compensability of the condition, but set it aside to the extent that it denied treatment associated with claimant's low back.

ORS 656.268(3) authorizes an insurer to close a claim by notice of claim closure "[w]hen the medical reports indicate to the insurer . . . that the worker's condition has become medically stationary and the insurer . . . decides that the claim is disabling but without permanent disability." A claimant then may request that the Evaluation Division review the matter and issue a Determination Order. In the present case, claimant did request review by the Evaluation Division and the Division set aside the insurer's notice of claim closure on the ground that claimant was not medically stationary at the time it was issued. According to ORS 656.005(17), "'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

After our de novo review of the evidence generated through the date of the Evaluation Division's order, we conclude that the insurer's notice of claim closure was proper with regard to claimant's physical condition. By that time, the physical injury to claimant's low back had been thoroughly evaluated and had been declared medically stationary by Drs. Gatterman, Bussanich and Duff. The other examining doctors and claimant's treating chiropractor did not dispute this latter conclusion. Surgery had been considered and rejected. Under these circumstances, the fact that claimant had a bulging disc and that Dr. Berovic had scheduled an apparently routine examination of claimant by Dr. Smith were not a sufficient basis for concluding that claimant's physical condition was not medically stationary.

This brings us to the issue of the insurer's partial denial relating to claimant's psychological condition. If the psychological condition is compensable, there is no indication in the record that it was medically stationary when the insurer issued the notice of closure. Claim closure was premature, therefore, if the psychological condition is compensable. See Rogers v. Tri-Met, 75 Or App 470, 473 (1985).

In his written closing argument to the Referee, claimant contended that the denial was invalid on procedural grounds because it was issued prior to the notice of claim closure. We agree. See Roller v. Weyerhaeuser Co., 65 Or App 583, adhered to on reconsideration, 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), rev den 297 Or 124 (1984). However, in view of the insurer's subsequent action of issuing the notice of claim closure, we nonetheless may proceed to the subject matter of the denial. See Maddocks v. Hyster Corp., 68 Or App 372, 374, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., supra, 65 Or App at 732 n.2.

From the record as a whole and Dr. Voiss's reports in particular, we find that claimant had a preexisting psychological condition at the time of his 1983 industrial injury. In order to prove a compensable relation between the industrial injury and the psychological condition, therefore, claimant must establish that his industrial injury was a material contributing cause of a worsening of the condition. See Chatfield v. SAIF, 70 Or App 62, 66 (1984).

We conclude that claimant failed to carry this burden for two reasons. First, the Referee's negative credibility assessment causes us to question the genuineness of claimant's somatic complaints. Second, to the extent that those complaints may be genuine, they do not represent a worsening of the psychological condition. As indicated by Dr. Voiss's reports, claimant has experienced psychologically-induced syptoms throughout his body, including his low back, for at least a decade. A continuation of symptoms does not represent a worsening of the psychological condition. See Chatfield v. SAIF, supra, 70 Or App at 68. We uphold, therefore, the insurer's denial of claimant's psychological condition, including its somatic symptoms, and conclude that the notice of claim closure was not prematurely issued.

This leaves the issue of the denial of chiropractic treatments in excess of two per month. In light of our decision that claimant's psychological condition and its symptoms are not compensable, we agree with the Referee that claimant has failed to establish that more than two treatments per month are either causally related to his industrial injury or reasonable and necessary.

Because of its decision on the premature closure issue, the Evaluation Division has not yet had an opportunity to consider the issue of extent of disability. On this issue, we remand the case to the Evaluation Division for its consideration pursuant to ORS 656.268(3).

ORDER

The Referee's order dated August 7, 1986 is affirmed in part, reversed in part and modified in part. That portion of the order relating to the Order of the Workers' Compensation Department dated January 8, 1986 is reversed. The order of the Workers' Compensation Department is set aside and the insurer's notice of claim closure dated November 25, 1985 is reinstated and affirmed on the premature closure issue. The case is remanded to the Evaluation Division for its consideration of the issue of extent of disability pursuant to ORS 656.268(3). That portion of

services dated March 25, 1985 is affirmed. That portion of the order relating to the insurer's denial of claimant's psychological condition dated November 22, 1985 is modified and the denial of the psychological condition and any treatment relating thereto is upheld. The attorney fee of $1,000 relating to this denial is reversed.

JOSEPH A. DEFELICE, Claimant
Stephen L. Brischetto, Claimant's Attorney

WCB TP-87010
October 16, 1987
Third Party Interim Order

Claimant has petitioned the Board for resolution of a dispute concerning the proper distribution of the proceeds of a third party settlement. ORS 656.593(3). The dispute involves the insurer's entitlement to a lien for anticipated future expenditures.

It has come to the Board's attention that a request for hearing is currently pending in WCB Case No. 86-13532. One of the issues to be addressed in the hearing request is the extent of claimant's permanent disability resulting from his November 13, 1985 compensable injury.

Inasmuch as there has not been a final order determining the extent of claimant's permanent disability arising out of his compensable injury, we deem it appropriate to hold this third party distribution proceeding in abeyance. John J. O'Halloran, 34 Van Natta 1504 (1982). Upon final resolution of the permanent disability issue in WCB Case No. 86-13532, the parties shall so advise the Board. At that time, the Board shall resume its review of this third party dispute.

IT IS SO ORDERED.

KENNETH J. HOWELL, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 85-11896
October 16, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee T. Lavere Johnson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Although claimant has not formally cross-requested review, he argues that he should receive an extraordinary attorney fee for services before and at the hearing. The issues are compensability and attorney fees.

Claimant, 42 at the time of hearing, has worked for the employer, a plywood mill, since 1968. During that time, he has performed several jobs including handling veneer and pulling lumber off a green chain. Prior to 1968, he had no wrist complaints. In approximately 1983, however, he developed pain, numbness, and tingling in his forearms and hands. His symptoms worsened with the passage of time. In August 1985, Dr. Nathan, a hand specialist, examined claimant and recommended bilateral carpal tunnel release surgery. The next month, Dr. Singer, claimant's treating orthopedist, performed a right carpal tunnel release.

There are two medical opinions. Dr. Nathan testified, by way of deposition, that claimant had an underlying carpal tunnel "disease" that gradually developed into carpal tunnel "syndrome."

According to Nathan, claimant's work activities caused only an increase in symptoms, not a worsening of the underlying disease. Dr. Singer is of the opinion that claimant's need for treatment was precipitated by his work activities. Singer further opined that claimant's carpal tunnel syndrome is "[work] related."

Claimant credibly testified that there was a direct relationship between the severity of his symptoms and his work activities. Heavy work resulted in increased symptoms and his symptoms diminished as his activities lightened. His non-work activities included scuba diving, hunting, and fishing. These activities did not produce symptoms or bother claimant.

The Referee found that claimant's underlying carpal tunnel disease was "affected." Accordingly, the Referee concluded that claimant had proven an occupational disease claim. We disagree.

To establish a claim for an occupational disease, claimant must prove that his work activities were the major contributing cause of his bilateral carpal tunnel condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). If claimant's condition preexisted his employment, he must also prove that his work activities caused a worsening of his underlying condition producing disability or the need for medical services. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979).

In our view, the causation of claimant's carpal tunnel condition presents a complex medical question. Although claimant's credible testimony is probative, the resolution of this case largely turns on the medical evidence. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Here, Dr. Nathan is a hand specialist. Nathan persuasively explained his opinion that clamaint's underlying carpal tunnel disease was neither caused nor worsened by his work activities. Nathan's opinion is well reasoned and provides an accurate history of claimant's complaints and work history. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Although Dr. Singer is the treating surgeon, he is not a hand specialist. Moreover, Singer's opinion consists entirely of a "check the box" reply accompanied by the following explanation:

> "It was my opinion, based on my review of [claimant's] physical examination, that [claimant] represents one of the relatively uncommon instances in which I felt his carpal tunnel syndrome was [work] related."

Singer only stated that claimant's carpal tunnel syndrome is work related. However, we are unable to discern whether Dr. Singer concluded that claimant's work activities were the major contributing cause of either his condition, or a worsening of his preexisting carpal tunnel disease. Although "magic words" are not a condition precedent to compensability, we are unpersuaded by Singer's conclusory opinion. See McClendon v. Nabisco Brands, 77 Or App 412 (1986).

On this record, we find that claimant has not met his burden. Accordingly, we need not address the issue of whether claimant's attorney is entitled to an extraordinary attorney fee.

ORDER

The Referee's order dated December 31, 1986 is reversed. The self-insured employer's denial is reinstated.

WILLIAM B. JOHNSON, Claimant
S. David Eves, Claimant's Attorney
SAIF Legal (Salem), Defense Attorney

WCB 85-05078
October 16, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Caraventa's order that set aside a Determination Order which had reduced claimant's award of permanent disability relating to a head injury from permanent total disability to 25 percent (80 degrees) unscheduled permanent partial disability. The issue is extent of disability.

Claimant fractured his skull and sustained other injuries in April 1980 in a work-related motorcycle accident. He was 52 years old at the time. Claimant had previously sustained a head injury at four years of age and subsequently experienced dylexsic symptoms in school, including marked reading and writing difficulties. At age 16, he was only in the sixth grade and dropped out of school.

After a stint in the military, claimant worked for a number of years as a pastry chef and then as a jeweler and watchmaker. During this period, claimant received his GED, a degree in baking, a certificate in watchmaking and an associates degree in electrical engineering. He also successfully completed two years of schooling in hotel and restaurant management. In approximately 1966, claimant began working as an instrument technician for Oregon State University. His job was to help graduate students design and fabricate equipment used in lab work. He held this job until the date of the industrial accident. At a time in his life not revealed in the record, claimant obtained an airplane pilot's license.

Since 1946, claimant has experienced periodic blackout spells in which the left side of his body goes numb, his left eye goes blind and he loses consciousness. The condition has defied medical diagnosis.

Following the compensable motorcycle accident, claimant experienced memory and concentration difficulties. He was treated primarily by Dr. Rhoads, an internist, Dr. Knox, a neurologist, and Dr. Ackerman, a psychologist. In May 1981, Dr. Rhoads indicated that claimant was medically stationary from a physical standpoint and had no limitations relating to lifting, walking, standing, bending or stooping. He deferred to Dr. Knox regarding the impairment due to claimant's head injury.

Dr. Knox reported in July 1981 that claimant continued to have significant neurological impairment as evidenced by memory problems, speech difficulties and frequent headaches. He indicated that claimant was not capable of resuming his work as an instrument technician and should not pilot an airplane. He stated, however, that he was capable of driving a car. He also indicated that claimant might have psychological problems associated with his head injury, but deferred to Dr. Ackerman on that question.

After an extensive evaluation, Dr. Ackerman concluded that claimant did have significant brain impairment which was complicated by psychological problems. Regarding the brain impairment, Dr. Ackerman noted difficulties with memory which inhibited claimant's ability to learn, retain and retrieve information. Regarding the psychological component of claimant's condition, Dr. Ackerman stated that claimant had "given up" on the idea of returning to work and was content to lead a passive-dependent lifestyle. At the end of his report, Dr. Ackerman stated:

"[Claimant] is a most perplexing individual who claims and at times shows what appears to be a severe level of organic impairment, especially of memory. But on repeated, careful, and extensive testing, his apparent severe organic deficits don't make organic sense, and my best conclusion is that his memory defects and other organic impairments are moderate in severity. His organic brain status renders him employable; emotionally and practically speaking I doubt that he'll work again."

The claim was closed by Determination Order in November 1981 with a 30 percent unscheduled award. The award was later increased to permanent total disability by Opinion and Order and this award was affirmed by the Board.

A short time after claim closure, claimant was examined by Dr. Holland, a psychiatrist. Dr. Holland reported inconsistencies during the examination which caused him to suspect that claimant was not nearly as impaired as he initially appeared. He referred claimant to Dr. Lewisohn, a psychologist at the Oregon Health Sciences University, for a neuropsychological evaluation. Dr. Lewisohn's evaluation confirmed the presence of significant memory deficits and depression. Based upon this evalutation, Dr. Lewisohn concluded that claimant would find it very difficult to perform in occupational settings which were not highly repetitive. Dr. Holland expressed agreement with most of Dr. Lewisohn's report, but reiterated that claimant was not totally disabled. Instead, he rated claimant's impairment as moderate.

Dr. Holland reexamined claimant in August 1985. He again concluded that claimant was grossly overreporting memory difficulties and concluded that most of claimant's impairment was voluntary in nature. He referred claimant for another neuropsychological evaluation, this time by Dr. Kurlychek, a psychologist, and also ordered a brain CT scan. The CT scan showed no abnormality. After neuropsychological testing, Dr. Kurlychek concluded that claimant's brain impairment was negligible and that psychological factors, including secondary gain, were the major cause of his apparent memory difficulties. Dr. Holland reviewed Dr. Kurlychek's report, concurred in his conclusions and reduced his impairment rating from moderate to mild. After receiving the reports from Drs. Holland and Kurlychek, SAIF applied to the Evaluation Division for a reduction in claimant's award. A Determination Order issued in December 1985, reducing the award from permanent total disability to 25 percent unscheduled permanent partial disability.

Dr. Ackerman reexamined claimant in May 1986. He referred claimant to Dr. Knox for an MRI scan which showed a number of abnormal regions in the middle and anterior portions of the left temporal lobe. After examining claimant and reviewing the MRI scan, Dr. Ackerman critiqued Dr. Holland's report and stated that he considered claimant to be "disabled from competitive employment" through a combination of organic and psychological factors. Dr. Holland, in turn, critiqued Dr. Ackerman's interpretation of the MRI scan results and criticized his conclusions. He acknowledged, however, that an MRI scan is more sensitive to evidence of brain trauma than a CT scan. In August 1986, Dr. Knox, the treating neurologist, reported that he thought that claimant was permanently and totally disabled based upon his reexamination of claimant and his review of the MRI scan.

At the hearing, claimant testified concerning his memory limitations and his difficulties with daily activities. He testified that he often got lost while driving and sometimes ended up in a city other than the one for which he had started. He testified that he still flew his airplane occasionally, but only if someone else was with him.

SAIF called an investigator who presented several rolls of movie film which depicted claimant performing a number of complex activities without apparent difficulty, including driving a car, driving a tractor, operating the tractor's front scoop, working on aircraft and taxiing and flying an airplane. The investigator testified that he observed claimant on more than a dozen occasions between July 1984 and July 1986 and saw him perform these and other activities without any appearance of hesitation or disorientation. He also indicated that on one occasion on June 17, 1985, he saw claimant fly his airplane by himself. When recalled, claimant stated that he probably had flown alone a few times, but could not remember.

Dr. Holland testified and reiterated his opinion that claimant was not significantly impaired from an organic standpoint. SAIF also called a vocational counselor who testified that claimant could perform a number of jobs, including electronics assembly person, coil winder, dishwasher, duplicating machine operator, gas station attendant, grinder operator, kitchen helper, nursery/greenhouse worker and cannery worker.

In her order, the Referee accepted the opinions of Drs. Knox and Ackerman and reinstated the award of permanent total disability. She acknowleged apparent internal inconsistencies in claimant's testimony and conflicts between claimant's testimony and other portions of the record, but attributed these to memory difficulties. She discounted the opinion of Dr. Holland by stating, erroneously, that he was not aware of the results of the MRI scan.

Based upon our de novo review of the record, we conclude that SAIF has carried its burden of proving that claimant is not currently entitled to an award of permanent total disability. See ORS 656.206(5); Kytola v. Boise Cascade Corp., 78 Or App 108, 112, rev den 301 Or 765 (1986). Although we do not doubt that claimant sustained significant permanent impairment as a result of his April 1980 industrial accident, the opinions of Drs. Kurlychek and Holland, in combination with evidence that claimant is able to perform many complex activities, including flying an airplane by himself, convince us that claimant is presently employable in a number of gainful and suitable occupations. We also conclude, however, that the award of unscheduled permanent partial disability granted by the most recent Determination Order is inadequate.

In rating the extent of claimant's unscheduled permanent partial disability, we consider his impairment, as reflected in the medical record and the testimony at the hearing, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984). Claimant was 58 years old at the time of the hearing. Although he experienced learning difficulties early in life, he was largely able to overcome these difficulties and tests reveal that he is of average intelligence. His educational and work histories were stated earlier in our order.

Following our review of the record, we conclude that claimant's impairment is in the mildly moderate range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 128 degrees for 40 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury. As claimant has already received a 30 percent unscheduled award, the net award granted by this order is 10 percent (32 degrees). No offset is authorized for permanent total disability payments made pursuant to the Referee's order. See United Medical Laboratories v. Bohnke, 81 Or App 144, 146 (1986).

ORDER

The Referee's order dated October 29, 1986 is reversed. In lieu of the award of permanent total disability granted by the Referee and the award of 25 percent (80 degrees) unscheduled permanent disability granted by the December 1985 Determination Order, claimant is awarded an additional 10 percent (32 degrees) unscheduled permanent partial disability for the compensable consequences of his head injury, giving him a total unscheduled permanent disability award to date of 40 percent (128 degrees). In lieu of the attorney fee awarded by the Referee, claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $3,000.

BILLIE A. KITTEL, Claimant
Steven C. Yates, Claimant's Attorney
E. Jay Perry, Defense Attorney
Edward C. Olson, Defense Attorney

WCB 86-15336 & 86-08843
October 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Howell's order that: (1) upheld North Pacific Insurance Company's denials of compensability and responsibility of her occupational disease claim for bilateral carpal tunnel syndrome; (2) upheld Liberty Northwest Insurance Corporation's denial of compensability and responsibility for the same condition; and (3) declined to assess penalties and attorney fees against North Pacific for its alleged unreasonable delay in denying her claim and in paying interim compensation. The issues are compensability/responsibility and penalties and attorney fees.

We affirm the Referee on the issue of compensability. We modify that portion of the Referee's order that declined to assess penalties and attorney fees for North Pacific's untimely denial of claimant's occupational disease claim.

North Pacific received a Form 827, "First Medical Report For Workers' Compensation Claims," on January 9, 1986. It did not issue a letter of denial until September 15, 1986. The Referee found that even though North Pacific's delay in issuing its denial was "unreasonable," there were no "amounts then due" upon which to assess a penalty. We agree with the Referee. However, pursuant to Spivey v. SAIF, 79 Or App 568, 572 (1986), claimant's attorney is entitled to a reasonable attorney fee.

ORDER

The Referee's order is modified in part and affirmed in part. Claimant's attorney is awarded a reasonable attorney fee of

$200 for North Pacific Insurance Company's untimely denial of claimant's occupational disease claim. All remaining portions of the Referee's order are affirmed.

JAMES E. REED, Claimant
Francesconi & Cash, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 86-13730 & 86-15350
October 16, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Liberty Northwest Insurance Corporation on behalf of its insured, General Foods Corporation, requests review of that portion of Referee Seymour's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Liberty Northwest on behalf of its insured, Oregon Turkey Growers, cross-requests review of those portions of the order that: (1) set aside its denial of diagnostic medical services relating to claimant's bilateral carpal tunnel syndrome and (2) assessed a penalty and attorney fee for an allegedly unreasonable denial of compensability. Compensability was later conceded and an order was issued pursuant to ORS 656.307. In his brief, claimant contends that the Referee erred in awarding his attorney an attorney fee out of his compensation for procuring the .307 order and argues that Liberty Northwest should have been ordered to pay the fee. The issues are responsibility, medical services, penalties and attorney fees.

Claimant began working as a "cropper" for Oregon Turkey Growers on April 7, 1986. Before that time, he had never experienced any problems with or symptoms in his hands. His job was to remove the crop (or gullet) and windpipe of decapitated birds that were moving past him on a cable. To do this, claimant would grasp the skin of the neck of each bird with his right hand and then remove the crop and windpipe with the fingers of his left hand. He performed this operation about once every 10 seconds.

After working two days (a total of 10 hours), claimant began to experience pain in his left index finger. He continued working sporadically as work was available and put in a total of another 23 hours in April. At the end of April, claimant filed an 801 form stating that he was experiencing extreme pain in his left index finger and loss of grip strength in his left hand. He sought treatment from an internist, Dr. Sanders, who diagnosed tendinitis of the left index finger and prescribed conservative treatment.

Claimant worked another 34 1/2 hours in May and his left hand pain and dysfunction worsened. As his left hand symptoms became unbearable toward the end of the month, he began cropping for short periods with his right hand to allow his left hand time to recover to the point where he could resume using it. He worked 25 3/4 hours in June and six hours in July. He left his job as a cropper on July 9. Liberty Northwest, on behalf of Oregon Turkey Growers, accepted claimant's claim for left index finger tendinitis on July 11.

On July 15, 1986, claimant was examined by Dr. Schwarz, a neurologist, on referral from Dr. Sanders. Dr. Schwarz performed nerve conduction studies and diagnosed bilateral carpal tunnel syndrome, worse on the left. The following day, claimant

began working for General Foods Corporation on the sanitation crew of a cannery. (Actually, claimant had worked for General Foods for one shift on the strawberry belt on June 13, 1986, but there is no evidence that this activity either actually or potentially affected claimant's upper extremity conditions or symptoms.) The sanitation job involved scrubbing equipment with brushes and the use of a high pressure water hose at least forty hours per week. Claimant avoided using his left hand as much as possible and his left-sided symptoms improved. Within a couple of weeks, however, he began to experience worsening symptoms in his right hand. Dr. Sanders referred claimant to Dr. White, a neurosurgeon, for further treatment and possible surgery.

By mid-August, the symptoms in claimant's right hand had increased to the point that they were about the same as those in his left hand. Claimant continued working in the cannery until September 9, when the crop that the cannery was processing was completed. He then filed an aggravation claim against Oregon Turkey Growers and a new injury claim against General Foods. Liberty Northwest issued denials on behalf of both employers. The denial on behalf of Oregon Turkey Growers denied compensability as well as responsibility. After some delay, however, compensability was conceded and an order pursuant to ORS 656.307 was issued on December 12, 1986.

The only medical opinion in the record to address the question of whether claimant's employment at the cannery worsened his condition was by Dr. White in late October 1986. He stated: "[Claimant's] symptoms were well established, very symptomatic, and I don't think it is fair to state that the [work at the cannery] contributed materially to this condition. I feel this occurred at Oregon Turkey Growers." In his testimony, claimant appeared at one point to deny that he experienced any symptoms in his right hand during his employment with Oregon Turkey Growers. Other portions of his testimony and the medical record, however, indicate that he did have some minimal right hand symptoms during this period. We conclude that claimant did in fact experience symptoms in his right hand while working for Oregon Turkey Growers, although they were much less severe than those in the left hand until after he began working in the cannery.

The Referee found that claimant's work at the cannery contributed to a worsening of his symptoms and caused claimant to be disabled from work. On those bases, he found General Foods responsible for claimant's bilateral carpal tunnel syndrome. He also concluded, however, that Oregon Turkey Growers should be responsible for the diagnostic tests performed by Dr. Schwarz because they were associated with the accepted left hand tendinitis claim and claimant had not yet begun working at the cannery at the time of the tests. The Referee also ordered Liberty Northwest to pay a penalty and attorney fee in connection with their denial of compensability on behalf of Oregon Turkey Growers on the ground that there was no reasonable basis for such a denial. Because an order pursuant to ORS 656.307 ultimately had issued and claimant's attorney had been instrumental in its issuance, the Referee awarded claimant's attorney an attorney fee out of claimant's compensation under the rule of Mark L. Queener, 38 Van Natta 882 (1986).

The Board affirms the Referee's order on the issues of penalties and attorney fees and, in view of our decision on the

responsibility issue, on the medical services issue as well. We reverse the Referee's order on the issue of responsibility.

The key event for determining responsibility in an occupational disease setting is the date of disability. Bracke v. Baza'r, Inc., 293 Or 239, 247-49 (1982). The date of disability for claimant's bilateral carpal tunnel syndrome occurred when claimant sought treatment for the condition. See United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983). Although carpal tunnel syndrome was not diagnosed initially and it is not clear precisely when the condition first appeared, the condition was diagnosed by Dr. Schwarz on July 15, 1986. By that date at the latest, therefore, claimant had sought treatment for the condition.

The next step is to identify the most recent employment prior to the date of disability which provided conditions capable of causing the disease. Bracke v. Baza'r, Inc., supra, 293 Or at 248-49. The employer providing such conditions is responsible for the disease unless work activity at a later employment independently contributed to a worsening of the underlying condition. See id. at 250; Boise Cascade v. Starbuck, 296 Or 238, 243 (1984); cf. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

As of July 15, 1986, the date of disability in the present case, the only prior employment providing conditions capable of causing claimant's carpal tunnel syndrome was that with Oregon Turkey Growers. Under the rules just stated, therefore, Oregon Turkey Growers is responsible for claimant's condition unless the subsequent work activity at General Foods independently contributed to a worsening of the underlying condition.

There is no evidence that claimant's employment with General Foods independently contributed to a worsening of his left carpal tunnel syndrome. If anything, the evidence supports the conclusion that the condition improved. Claimant avoided using his left hand while working at the cannery and his symptoms decreased. Oregon Turkey Growers, therefore, remains responsible for claimant's left carpal tunnel syndrome.

The only evidence which suggests a worsening of claimant's underlying condition is that the symptoms in his right hand worsened after he began working in the cannery. The only medical report in the record on the question, however, indicates that the underlying condition did not worsen. That opinion may perhaps be faulted in that it speaks of a "material" contribution rather than an independent contribution and does not distinguish between the right and left-sided conditions. Any ambiguities in the opinion, however, must be charged against the party with the burden of persuasion, Oregon Turkey Growers. See Eva L. (Doner) Staley, 38 Van Natta 1280, 1281 (1986). We conclude, therefore, that claimant's employment with General Foods did not independently contribute to a worsening of the underlying condition and assign responsibility for the bilateral condition to Oregon Turkey Growers.

Claimant's attorney is entitled to an insurer-paid attorney fee for services on Board review. The attorney submitted a one-paragraph argument in favor of the position that finally prevailed. See ORS 656.386(1); SAIF v. Phipps, 85 Or App 436, 438-39 (1987).

ORDER

The Referee's order dated January 8, 1987 is reversed in part. Responsibility for claimant's bilateral carpal tunnel syndrome is assigned to Oregon Turkey Growers and its insurer, Liberty Northwest Insurance Corporation. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $100 for services on Board review, to be paid by Liberty Northwest on behalf of Oregon Turkey Growers.

The Beneficiaries of
ERNEST L. SHENK (Deceased), Claimant
Brown & Tarlow, Claimant's Attorneys
SAIF Legal (Salem), Defense Attorney

WCB 85-07872
October 16, 1987
Order on Reconsideration

Reviewed by Board Members Ferris and Lewis.

Claimant, as beneficiary of the deceased worker, has requested reconsideration of that portion of the Board's October 2, 1987 order that awarded an insurer-paid $700 attorney fee for prevailing on Board review against the SAIF Corporation's appeal from a Referee's order. Contending that her counsel expended a great deal of time defending the Referee's finding concerning the complex issue of compensability for her deceased husband's myocardial infarction, claimant asks that her attorney fee be increased to $2,975.

If a request for Board review is initiated by an employer or insurer, and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to claimant or claimant's attorney a reasonable attorney fee in an amount set by the Board. See ORS 656.382(2). Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained.

In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss these factors should not be taken to mean that they were not carefully considered in determining a reasonable attorney fee. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

Here, in determining claimant's attorney fee award, the aforementioned points and authorities were fully considered. On reconsideration, we continue to find that a $700 attorney fee for services on Board review is reasonable.

Accordingly, claimant's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

DEAN D. ANDERSON, Claimant
Joseph T. Mcnaught, Claimant's Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 86-07003
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Mulder's order that set aside its denial of claimant's industrial injury claim relating to his right leg. The issue is whether the accident which gave rise to the injury arose out of and in the course of claimant's employment.

Claimant fractured his right lower leg in April 1986 when he fell down some steps at a restaurant. At the time of the accident, claimant was on an unpaid lunch break from his job as a route driver and salesman for a baking company and was being accompanied by Mike Robinson, the owner of a convenience store at which claimant regularly made deliveries. Claimant did not customarily eat lunch in a restaurant because of the expense, but he was often in the area of Robinson's store at about noon and the two dined together once or twice per month on the average. They took turns paying for the lunches and discussed a variety of personal and business subjects. Both indicated that they thought the lunches helped maintain a good business relationship, although Robinson indicated that he dealt with the employer because of the good delivery service he received. Claimant and Robinson had no social contact outside their occasional lunch outings.

Claimant was paid on a salary plus commission basis. He and his fellow drivers had been encouraged by the employer in periodic company meetings to maintain good customer relations and to promote the employer's products during delivery stops. The employer, however, had never instructed or encouraged its employees to take customers out to lunch, although, on one occasion while riding with claimant on his route, claimant's supervisor had accompanied claimant and Robinson to lunch. The employer did not reimburse claimant or any other employee for expenses associated with such outings. Claimant did not dine with any of the customers on his route besides Robinson.

On the date of the injury, claimant entered Robinson's store a short time before noon and Robinson asked if he wanted to go to lunch. Claimant replied that he did and offered to pay. The two rode to the restaurant in Robinson's car. Claimant had nothing relating to business which he intended to discuss with Robinson that day. As usual during his work day, claimant was wearing a uniform bearing his employer's insignia. Claimant fell and was injured shortly after he and Robinson entered the restaurant.

The Referee concluded that claimant's injury arose out of and in the course of his employment through an application of factors enunciated in several Court of Appeals cases relating to employee social and recreational activities. We conclude that this analysis was misplaced. The evidence suggests two theories for bringing claimant's lunchtime activity within the ambit of his employment. The first theory is that the activity was part of his employment by virtue of his role as a salesman and the fact that he was going to lunch with a customer. The second theory is that the activity was incidental to his employment by virtue of his role as an outside employee and the fact that he was engaged in personal comfort activity.

Regarding the first theory, Professor Larson, in his discussion of entertaining clients and customers, states:

> "Since the danger of this kind of liability's getting out of hand is obvious, it should be stressed that the authority of the particular employee to undertake recreational activities on behalf of his employer must be genuine, and cannot be taken for granted merely because the employee is on [an outing] with someone with whom the employer has actual or potential business relations. Relevant factors in determining the existence of such authority would include the extent to which this kind of employee might generally be expected to have this function or authority, the extent to which the recipient of the entertainment is in a position to make decisions that would benefit the employer, the degree of actual authority conferred on this particular employee by specific act or by custom, the amount of direct, substantial benefit derived by the employer beyond the intangible value of improvement of employee health and morale, and the extent to which the employer pays for the cost of the entertainment." 1A A. Larson, The Law of Workmen's Compensation §22.21(d) at 5-102 to 5-104 (1985).

After considering the factors listed by Larson in the above quotation, we conclude that this theory fails to demonstrate a material causal connection between the activity which gave rise to claimant's injury and his employment. Claimant was not the kind of employee who would generally be expected to entertain customers, had never been authorized by the employer to do so and was not reimbursed for expenses associated with such activity. The benefit which the employer derived from the activity was indirect and insubstantial at best. Although both claimant and Robinson testified that their lunch outings helped maintain a pleasant business relationship, there is no evidence suggesting that Robinson would not have continued to deal with the employer in the absence of such outings. On the contrary, Robinson indicated that he continued to deal with the employer because of the good delivery service he received. In addition, the fact that claimant did not eat lunch with any of his other customers and that he was usually in the area of Robinson's store around noon indicates that the occasional outings with Robinson were a matter of personal preference and convenience rather than part of his employment. We, therefore, reject the first theory.

Regarding the second theory, Professor Larson indicates that a major space and time deviation from a fixed route by an outside employee for personal comfort activity breaks the causal connection between the personal comfort activity and the employment. 1 A. Larson, supra, §19.63. Minor deviations such as crossing the street to buy a little food or something to drink or stopping momentarily to use a rest room, on the other hand, do not break the connection. In the present case, claimant's trip to the

restaurant was a major space and time deviation from his normal route. Claimant left his truck and rode a substantial distance with Robinson to a restaurant for an extended unpaid break from work activity. Under these circumstances, we conclude that claimant's activity in the restaurant was not incidental to his employment so as to make the injury sustained one arising out of and in the course of his employment. See Clinton L. Maddock, 37 Van Natta 189 (1985). Having rejected both theories, we conclude that the insurer's denial should be reinstated and affirmed.

ORDER

The Referee's order dated December 15, 1986 is reversed. The insurer's denial dated May 2, 1986 is reinstated and affirmed.

TAMARAH ANDERSON, Claimant
Vick & Gutzler, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-15062
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Leahy's order which set aside its denial of claimant's occupational disease claim for reactive airways disease. On review, the insurer contends that claimant's condition is not compensable. We agree and reverse.

Claimant was 29 years of age at the time of hearing. Her employment experience includes work as a cashier, waitress, deli manager, and insurance policy server. She worked part time for two months in 1981 as a molding machine operator for this employer. She testified that she did not experience any breathing difficulties during this time.

Claimant returned to this employer in February 1986 as a full-time machine operator. She found that working conditions had changed since 1981. The company's plant was much larger and, as a result, emitted greater "fumes and stuff" from burning material. Four months later, claimant began to experience shortness of breath and tightness in her chest, particularly when working in areas of reduced ventilation.

Claimant sought treatment in September 1986, and was later diagnosed as having reactive airways disease, with symptoms of rhonchi and bilateral expiratory wheezing. She terminated her employment in mid-September after an asthmatic attack at work, and filed a claim. In October 1986, the insurer denied the claim.

Claimant testified that she has had no prior asthmatic attacks. She has been smoking cigarettes since the age of 17, but denies any associative breathing difficulties. She reported having a few sinus and upper respiratory infections in the past; however, none of them required hospitalization.

The record contains medical reports and opinions from four physicians: Dr. Cummings, claimant's family physician; Dr. Coleman, a pulmonary disease specialist; Dr. O'Hollaren of the Allergy Clinic; and Dr. Mantanaro, assistant professor of medicine in the Divisions of Allergy and Clinical Immunology at the Oregon Health Sciences University.

Dr. Cummings diagnosed claimant's condition in September 1986 as asthmatic bronchitis. He prescribed medication and advised her repeatedly to quit smoking. Dr. Cummings later opined that claimant's disability was "due to asthma which appears to have been caused by breathing fumes at [the employer]."

Also in September 1986, Dr. Coleman saw claimant on referral from Dr. Cummings. After examining claimant and reviewing her medical history and symptoms, Dr. Coleman diagnosed "[p]robable reactive airways disease." He noted that claimant gave a "classic history for reactive airways disease exacerbated by exposure to fumes in her work environment." He felt certain that she at least had an "exacerbation of hyperreactivity [of the airways] presenting with symptomatic wheezing and dyspnea." Accordingly, he explained that claimant may have had a preexisting "hyperreactive airways" condition, which was "relatively asymptomatic" prior to working with the employer, but which resulted in a "nonspecific reaction" when exposed to fumes at work.

However, Dr. Coleman also acknowledged as "quite possible" that claimant's lungs had become "sensitized" through work exposure, resulting in her "asthma-like illness." Dr. Coleman observed that claimant's years of cigarette smoking "complicate[s] her history." He "strongly encouraged" claimant to quit smoking, noting that "[smoking] will tend to exacerbate any underlying reactive airways disease problem."

In November 1986, Dr. Coleman reported that he "was concerned that [claimant] had developed reactive airways disease (asthma) as a result of exposure to irritating substances in her work environment," but that he was unable to provide specific documentation of the causal relationship between claimant's employment and the development of asthma. Nevertheless, Dr. Coleman noted: "I have had the opportunity to be involved in a number of cases in which occupational asthma was implicated, and I felt that [claimant] was at high risk to have developed this [asthma] condition."

Dr. O'Hollaren saw claimant on several occasions in December 1986. He reviewed her medical history, conducted pulmonary studies, and administered tests for a few significant allergens. He concluded that claimant had bronchial asthma, the symptoms of which have "undoubtedly been aggravated by exposure to strong fumes and odors at work." He noted that claimant's smoking "further aggravates her bronchial problem."

Dr. O'Hollaren added that, because claimant apparently had no history of prior asthmatic episodes, "it would appear that the exposure at work definitely precipitated or aggravated her asthma." Dr. O'Hollaren also analyzed the chemical content of claimant's work exposure to determine whether her asthmatic condition was occupationally related. However, he could not identify any specific allergens in the fumes which causes occupational asthma, prompting him to conclude: "[W]e must assume that [the fumes are] mainly an irritant to an already irritable airway or asthmatic condition."

Dr. O'Hollaren advised that claimant not expose herself to any more noxious or irritating fumes, noting that she may need continued treatment for asthma for an indefinite period.

In December 1986, Dr. Mantanaro conducted an independent medical examination. Dr. Mantanaro diagnosed reactive airways

disease, noting the following "multiple triggers": (1) upper and lower respiratory tract infections, (2) emotional stress, (3) exercise, and (4) "[i]rritants." He also diagnosed chronic bronchitis from claimant's 12-year history of cigarette smoking.

Dr. Mantanaro also submitted a comprehensive analysis, in which he opined that claimant did not have occupational asthma:

> "In order to meet the criteria for the definition of occupational asthma, [claimant] must have developed symptoms that she would not have developed without her occupational exposures. This clearly is not the case as by her own history she has developed worsening symptoms with upper respiratory tract infections, emotional stress and exercise.

Dr. Mantanaro apparently concluded, instead, that claimant had a preexisting reactive airways condition, the symptoms of which were aggravated by work exposure. After reviewing claimant's occupational exposures, he found that she had been exposed to a number of respiratory irritants. Dr. Mantanaro observed that "[t]hese [occupational] substances are known to cause transient aggravation of symptoms in individuals with reactive airways disease but are not known to be responsible for the induction of the reactive airways disease." He further noted: "It is important to point out that in fact she continues to expose herself voluntarily to one of the most potent respiratory irritants known, that being cigarette smoke."

Claimant testified that she continued to experience breathing difficulties in fog, during aerobics, and while under a lot of emotional stress. These difficulties are best endured after medication, which she takes daily.

Relying primarily upon claimant's "believable" testimony and the medical reports and opinions of Drs. Cummings and Coleman, the Referee found sufficient evidence that: (1) claimant's work exposure resulted in a worsening of her reactive airways condition; and (2) the exposure was the major contributing cause of the worsening. Consequently, the Referee found the claim compensable.

To establish compensability, claimant must prove that work conditions caused a worsening of her underlying condition producing disability or the need for medical services. Weller v. Union Carbide, 288 Or 27, 35 (1979). She must also establish that her work conditions were the major contributing cause of the worsening of her preexisting condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982). A mere recurrence or exacerbation of symptoms is insufficient to establish a compensable condition. Wheeler v. Boise Cascade, 298 Or 452, 457-58 (1985).

We agree with the Referee's finding that claimant's reactive airways condition preexisted her employment. Furthermore, we find, based on claimant's lack of prior asthmatic episodes, that her condition was asymptomatic at the time of employment. However, after reviewing de novo the medical and lay evidence, we are not persuaded that claimant's work conditions were the major contributing cause of any worsening of her underlying condition.

As a threshold matter, claimant bore the burden of

establishing, by a preponderance of the evidence, a worsening of her reactive airways condition, as opposed to a mere exacerbation of her symptoms. Wheeler v. Boise Cascade, supra. In finding the requisite worsening of the condition, the Referee was persuaded by claimant's argument that two of her doctors had found a change in her condition. One of these changes is Dr. Cummings' finding that claimant had developed rhonchi bilaterally and bronchitis. The other change is Dr. Coleman's report that claimant has had an "exacerbation of hyperreactivity [of the airways] presenting with symptomatic wheezing and dyspnea."

We find neither report persuasive. Dr. Cummings' finding reflects a mere symptomatic development and is not probative of any worsening of the condition itself. Dr. Coleman's report suggests a worsened condition but is far too vague to sustain claimant's burden of proof on this question.

Rather, we are more persuaded by Dr. Mantanaro's report. Dr. Mantanaro, an allergy specialist, examined claimant, reviewed her history, conducted a laboratory evaluation, and compiled a complete allergy profile. He thereafter found that the irritants in claimant's work exposure are known to cause "transient aggravation of symptoms" in persons with the reactive airways condition. Dr. Mantanaro's report is bolstered by that of another allergy specialist, Dr. O'Hollaren, who reported that "[claimant's] symptoms have undoubtedly been aggravated by exposure to strong fumes and odors at work." Thus, the evidence preponderates that claimant sustained a mere exacerbation of symptoms, not a worsening of her underlying reactive airways condition.

Claimant also fails to establish that work conditions were the major contributing cause of any alleged worsening of condition. We note at the outset that exact legal terminology in the medical reports or opinions is not required to establish the requisite causation element. See Garbutt v. SAIF, 297 Or 148, 151-52 (1984); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986); Johannesen v. N.W. Natural Gas Co., 70 Or App 472, 477 (1984). However, credible expert medical evidence is generally necessary to establish a prima facie case of causation in all cases that are not "uncomplicated". Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Wilson v. SAIF, 28 Or App 509, 511-12 (1977). We do not characterize this occupational disease claim as "uncomplicated." Consequently, credible medical evidence is accorded significant probative value, though lay testimony is by no means rejected.

It is undisputed that none of claimant's physicians could identify the specific agent causing her reactions. Nevertheless, after reviewing the medical evidence and lay testimony, we are persuaded that work exposure, to some degree, caused claimant's reactions. However, none of the physicians could quantify the relative degree of causation attributable to claimant's work conditions. Dr. Cummings, claimant's treating physician, opined that her worsened condition "appear[ed]" to have been caused by work conditions. The opinion's speculative connection between claimant's work exposure and her underlying condition renders it insufficient to establish a compensable relationship. Gormley v. SAIF, 52 Or App 1055,1060 (1981). Moreover, Dr. Cummings acknowledged his lack of expertise concerning this question when he referred claimant to Dr. Coleman for evaluation of "whether or not this is occupational disability".

Two of the specialists who examined claimant agreed that her reactions resulted from work exposure. Dr. Coleman, a pulmonary specialist, opined that claimant may have experienced a "nonspecific reaction" as a result of work exposure. Dr. O'Hollaren, an allergy specialist, reported that claimant had bronchial asthma, the symptoms of which were aggravated by work exposure. Only Dr. Mantanaro, another allergy specialist, opined that claimant's asthma was not occupationally related. However, he based his opinion on historical data which claimant later disputed at hearing, therebydiminishing its persuasiveness.

All three specialists did agree, however, that claimant's years of cigarette smoking aggravate her condition. Dr. Coleman noted that claimant's cigarette smoking "will tend to exacerbate any underlying reactive airways disease problem." Dr. O'Hollaren reported that claimant's smoking "further aggravates her bronchial problem." Dr. Mantanaro agreed, calling cigarette smoke "one of the most potent respiratory irritants known."

Thus, the medical evidence establishes that both work exposure and cigarette smoking caused claimant's reactions. Yet, none of the aforementioned physicians assigned a relative degree of causation to either cigarette smoke or work exposure. Consequently, there is no medical evidence that identifies claimant's work exposure as the major contributing cause of her condition.

Given the medical complexity of the causation question here, claimant's lay testimony alone is insufficient to establish her prima facie case. Accordingly, after reviewing this record, including claimant's testimony, we are not persuaded that she has established the compensability of her condition.

ORDER

The Referee's order dated January 12, 1987 is reversed. The insurer's denial is reinstated and upheld.

EDWARD ANSELMI, Claimant
Black, et al., Claimant's Attorneys
Beers, et al. Defense Attorneys
SAIF Corp Legal, Defense Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-06114, 85-08255, 85-12276 & 86-03455
October 19, 1987
Order on Reconsideration

The SAIF Corporation requests reconsideration of the Board's September 21, 1987 Order on Review that found Liberty Northwest Insurance Corporation responsible for claimant's medical services claim for a left and right shoulder condition. Specifically, SAIF contends that it should not be held responsible for an insurer-paid attorney fee awarded by the Referee. We agree and modify our prior order.

The Referee allocated responsibility for claimant's medical services to three insurers for the specific period in which it was on the risk. Therefore, EBI Companies was held liable up through the date SAIF assumed coverage, SAIF was held liable up through the date Liberty came on the risk, and Liberty was held responsible thereafter. In addition, the Referee allocated claimant's insurer-paid attorney fee between the three insurers.

We found the allocation of responsibility impermissable. Because claimant's employment during the period in which Liberty was

on the risk independently contributed to a worsening of his underlying condition, we concluded that Liberty was entirely responsibile for the medical services claim. Yet, in so doing, we neglected to modify the Referee's allocation of the attorney fee award.

Although neither insurer questioned the compensability of the claim, no paying agent was designated under ORS 656.307. Inasmuch as claimant actively participated and finally prevailed on his claim against Liberty, we conclude that he is entitled to attorney fees under ORS 656.386(1) for services at the hearing. Stovall v. Sally Salmon Seafood, 84 Or App 612 (1987); Petshow v. Farm Bureau Ins. Co., 76 Or App 563, rev den 300 Or 722 (1986); see OAR 438-47-090. However, the attorney fee award should not have been allocated between the three insurers. Since Liberty has been found entirely responsible for the claim, it shall also be held entirely responsible for claimant's attorney fee award for services at the hearing.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as modified herein, we adhere to and republish our former order, effective this date.

DALE E. ATKINS, Claimant
Coons & Cole, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 86-03919
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Gruber's order that set aside its partial denial of claimant's medical services claim for a prosthetic device replacement. On review, the insurer contends that claimant's need for the prosthetic replacement is not causally related to his compensable injury. We agree.

In October 1978 claimant suffered a compensable right elbow injury. Surgery was required to set a comminuted fracture. Claimant was released to return to work in December 1978. However, due to continued pain and loss of range of motion, claimant underwent a second operation in April 1979. Dr. Ellison, surgeon, performed reconstructive surgery, which included inserting a "Swanson-type radial head prosthesis implant."

A September 1979 Determination Order awarded 40 percent scheduled permanent disability for loss of use of the right arm. Pursuant to a February 1980 Stipulation, this award was subsequently increased to a total of 60 percent.

Thereafter, claimant became self-employed, operating his own construction business. As owner and president of his company, claimant elected not to provide Workers' Compensation coverage on himself as an employee.

In February 1986 claimant returned to Dr. Ellison. Claimant stated that in December 1985, while working for his company, he had fallen from a building. Since the fall, he suffered continuous pain, intermittent swelling, stiffness and lack of mobility in his right elbow. X-rays revealed fracture of the prosthesis.

Considering the degree of claimant's activity, Dr. Ellison stated that he could "at some point" anticipate revising or replacing claimant's prosthesis. However, in the absence of any interval problems of significance from the 1978 replacement, Dr. Ellison concluded that the December 1985 injury necessitated claimant's need for further elbow surgery.

The Referee found that the damage to the prosthetic device could not have occurred if the device had not been implanted after the 1978 injury. Therefore, the Referee concluded that the compensable injury was a material contributing cause of the need for additional medical services. We disagree.

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 recovery requires. ORS 656.245. Claimant is entitled to medical services for conditions which are the direct and natural consequence of the original injury. Eber v. Royal Globe Insurance Co., 54 Or App 940, 943 (1981). To establish entitlement to the medical services, claimant must prove that his compensable right elbow injury remains a materially contributing cause for his present need for replacement of his prosthetic device. Grable v. Weyerhaeuser Co., 291 Or 397, 400-01 (1981). See also Florence v. SAIF, 55 Or App 467, 470 (1981).

Following our de novo review of the medical and lay evidence, we are persuaded that the December 1985 fall created an independent intervening injury to claimant's prosthetic device. Consequently, the record fails to establish that claimant's October 1978 compensable right elbow injury remains a material contributing cause to his current need for medical services. Accordingly, we conclude that the request is not compensable.

ORDER

The Referee's order dated February 24, 1987 is reversed. The insurer's denial dated Febuary 27, 1986 is reinstated.

DONALD J. BIDNEY, Claimant
Bloom, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-07460
October 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of Referee Lipton's order which modified the insurer's denial of claimant's request to be provided with "suitable transportation" to accommodate his disabilities. Asserting that claimant's request is not compensable, SAIF contends that the Referee's order should be reversed. We agree.

Claimant was 53 years old at the time of hearing. He compensably injured his back in October 1975 and February 1976. These injuries resulted in a September 1985 low back surgery. Additionally, claimant has a compensable psychological condition. As of his last award of compensation, an April 23, 1986 Own Motion Determination, claimant has received a total of 85 percent unscheduled permanent disability.

Shortly after the Own Motion Order, claimant requested "suitable transportation." Claimant contended that: (1) the entrance of his vehicle was too high; (2) bending his neck caused upper back spasms and breathing problems; (3) his present car seat did not support his back; (4) without cruise control, his right leg developed spasms and cramps and his ankle gave out; and (5) the lack of an arm rest to support his right arm resulted in pain and spasms in his arms, neck, chest and upper back.

To support his request for a modified automobile, claimant

supplied letters from Dr. Willeford, a family practioner, and Dr. Fleming, a clinical psychologist. Dr. Willeford opined that claimant's ability to walk and his physical activity was very limited, requiring him to be more sedate. Dr. Willeford further stated that claimant's only real locomotion was an "adequate vehicle." Dr. Fleming understood that claimant was having difficulty with his car, noting that claimant felt too "restricted" in it. Dr. Fleming expressed that:

> "[f]rom a psychological standpoint I feel it is very important that he be able to get out and to drive around, as this allows him to have control over his life and over his activities. Without this limited degree of control his life would be more restricted, and his depression would become more serious."

The Referee found that the evidence supported nothing more than the necessity to modify claimant's vehicle to provide better ingress and egress. He stated that this could be provided by either modifying claimant's present vehicle to install a driver's seat which rotates from a driving position to an exiting position or by SAIF paying the expense of such an option on a vehicle of claimant's choice. Consequently, the Referee modified SAIF's denial. We disagree.

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 recovery requires. ORS 656.245.

OAR 436-10-040 provides that:

> "[t]he insurer shall pay for all medical services which the nature of the compensable injury and the process of recovery requires. . . . Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. . . . Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury and the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments." (emphasis added).

See also James R. Frank, 37 Van Natta 1555, 1557 (1985).

Following our de novo review of the medical and lay evidence, which includes claimant's believable testimony, we are not persuaded that the reports provided in support of claimant's request, justify, with particularity, why claimant requires special modifications to his vehicle. See OAR 436-10-040. Furthermore, the record fails to support claimant's contention that his request is a reasonable and necessary service related to his compensable injury.

See ORS 656.245(1); see also Paul D. Weisenberger, 37 Van Natta 1038, 1040 (1985). Accordingly, we conclude that the request is not compensable.

ORDER

The Referee's order dated February 27, 1987 is reversed. The insurer's denial dated May 15, 1986 is reinstated and upheld.

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

WCB 86-03915
October 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Leahy's order which assessed penalties and accompanying attorney fees for an unreasonable denial of medical services. On review, the insurer contends that its denial was not unreasonable. We agree and reverse.

Claimant, 46 years old at the time of the hearing, was compensably injured in 1983 when her left arm was struck by a door frame. This injury resulted in surgery for a left tennis elbow. In January 1984, a lipoma was diagnosed and surgically removed. The insurer denied this condition. The question of compensability of this condition was resolved by a December 1984 Disputed Claim Settlement.

In January 1986, claimant returned to Dr. Carpenter, her treating orthopedic physician, with complaints of arm pain. She had not sought treatment since January 1984. Suspecting Reynaud's phenomena and a nerve deficit, Dr. Carpenter related claimant's condition to her original elbow injury. However, Dr. Carpenter also mentioned claimant's cigarette smoking, coffee consumption, and prior lipoma surgery as potential contributors. Dr. Carpenter referred claimant to Dr. Eisler, neurologist. On February 18, 1986, Dr. Eisler concluded that claimant's symptoms were more likely attributable to a "so-called resistant tennis elbow syndrome."

On February 20, 1986, the insurer denied responsibility for claimant's Reynaud's phenomena and nerve irritation. It was not until April 1986 that the insurer received Dr. Eisler's February 1986 report. In July 1986, stating that it had received further clarification from Drs. Carpenter and Eisler that claimant's current problems were related to her compensable injury, the insurer partially modified its February 1986 denial. It accepted responsibility for claimant's current treatment, but continued to deny responsibility for claimant's Reynaud's phenomena and nerve irritation. Shortly thereafter, the insurer paid the physicians' bills.

Finding that the insurer's earlier uncertainty concerning the compensability of the medical services should have been dispelled by its April 1986 receipt of Dr. Eisler's February 1986 report, the Referee found the insurer's conduct unreasonable. We disagree.

If the insurer unreasonably delays acceptance or denial of a claim or unreasonably refuses to pay compensation, it shall

be liable for penalties and attorney fees. ORS 656.262 (10). An unreasonable delay of payment of compensation should be determined on a case-by-case basis. See Williams v. SAIF, 31 Or App 1031, 1305 (1977).

In the present case, the insurer's February 20, 1986, denial was issued within the 60 day period for notice of acceptance or denial provided by statute. ORS 656.262(6). Furthermore, since it had already denied responsibility for claimant's current problems, it was not necessary for the insurer to issue another denial for the same problems after it received Dr. Eisler's February 18, 1986 report. Consequently, we do not find the insurer's failure to respond to Dr. Eisler's February 1986 report unreasonable.

Finally, in view of the number of other potential contributing causes to claimant's current condition that were mentioned in Dr. Carpenter's initial request, we do not consider the insurer's denial unreasonable.

Inasmuch as we do not consider the insurer's February 20, 1986 denial unreasonable, penalties and accompanying attorney fees are not justified.

ORDER

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

WILLIAM D. CAREY, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-10184
October 19, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Mulder's reissued order that: (1) found that his claim was not prematurely closed; and (2) declined to award interim compensation or related penalties and attorney fees. In its brief, the SAIF Corporation requests review of that portion of the order that set aside its "de facto" denial of claimant's medical services claim for surgery. The issues are premature claim closure, interim compensation, medical services, penalties and attorney fees.

We reverse that portion of the order that failed to award interim compensation from November 21, 1985. The remainder of the order is affirmed.

Claimant suffered a compensable back injury in June 1982. An August 1984 Determination Order awarded 10 percent unscheduled permanent disability. In September 1984 claimant was examined by Dr. Gerber, neurosurgeon, at the request of Dr. Neumata, his treating physician. Dr. Gerber noted that claimant complained of neck and back pain related to his 1982 injury. Following that examination, the August 1984 Determination Order was set aside by stipulation.

In June 1985 the Spokane Panel examined claimant. The Panel concluded that claimant was medically stationary with no objective evidence of impairment. Dr. Gerber concurred. Thereafter, an August 1985 Determination Order awarded no additional unscheduled permanent disability.

On November 21, 1985, Dr. Gerber stated that claimant continued to suffer from chronic neck pain and stiffness, shoulder pain, pain and numbness extending into the right arm, and low back pain with numbness in both legs. Concluding that his symptoms were basically unchanged from his September 1984 examination, Dr. Gerber recommended a cervical anterior fusion and discectomy. Consequently, Dr. Gerber opined that claimant was disabled from work until something was done to improve his condition.

Claimant asserts that Dr. Gerber's November 21, 1985 report constituted an aggravation claim obligating the insurer to begin the payment of interim compensation. Claimant seeks a penalty and attorney fee for the insurer's failure to timely process the claim. We conclude Dr. Gerber's report constituted an aggravation claim for the purposes of the payment of compensation. See ORS 656.273(6).

Pursuant to ORS 656.273(3), "[a] physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." Here, Dr. Gerber's November 1985 report indicated that claimant was in need of further treatment and was disabled from work until his condition improved. Inasmuch as Dr. Gerber's previous report had related claimant's neck and back condition to his compensable injury, we conclude that Dr. Gerber's November 1985 report constituted an aggravation claim that obligated the insurer to begin the payment of compensation. See ORS 656.273(6). Although SAIF did not issue a formal denial, claimant raised the issue of an aggravation claim on April 8, 1986. Accordingly, we find that he is entitled to interim compensation from November 21, 1985 to April 8, 1986. See William W. Soderwall, 38 Van Natta 544 (1986).

Although we have found that claimant is entitled to interim compensation, we do not consider the insurer's failure to process the aggravation claim unreasonable. In July 1985 Dr. Gerber concurred with a report from the Spokane Panel which stated that claimant did not need additional treatment. Further, in the November 1985 report, Dr. Gerber concluded that claimant's symptoms were basically unchanged from his September 1984 examination. Under these circumstances, we do not find SAIF's failure to recognize and process the report as an aggravation claim unreasonable. Consequently, penalties and attorney fees are not warranted. See ORS 656.262(10).

ORDER

The Referee's reissued order dated January 7, 1987 is affirmed in part and reversed in part. That portion of the order that declined to award interim compensation is reversed. Claimant is entitled to interim compensation from November 21, 1985 to April 8, 1986. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order, not to exceed $3,000, as a reasonable attorney's fee. The remainder of the order is affirmed.

STEVEN D. CLEMENT, Claimant
SAIF Corp Legal, Defense Attorney

WCB 84-00678
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant, pro se, requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of his occupational disease claim for an allegedly stress-induced mental disorder. With his brief, claimant has submitted a number of documents which were not

admitted at the hearing. We treat these submissions as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues are remand, timeliness and compensability.

Claimant's request for remand is denied. He was represented by an attorney at the hearing. The documents submitted on Board review either are dated prior to the hearing and thus could have been timely submitted or are irrelevant to the issues of the case. On the merits, the Board affirms the order of the Referee.

ORDER

The Referee's order dated September 19, 1986 is affirmed.

JOHN K. EDER (Deceased)
JANE EDER, Claimant
Pozzi, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 86-12509
October 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant, as beneficiary of the deceased worker, requests review of Referee Daughtry's order that: (1) found that claimant was entitled to $1,000 in funeral expenses; and (2) declined to assess penalties and attorney fees for the insurer's failure to pay medical benefits, penalties, and attorney fees pending review of a prior order. The issues are reimbursement for funeral expenses, and penalties and attorney fees.

The deceased worker retired from his employment in 1976. In 1982 he filed a claim for lung disease caused by his work-related exposure to asbestos. This claim was eventually found compensable. The deceased worker died in May 1985. Thereafter, the insurer denied claimant's claim for widow benefits. This denial was partially set aside by a prior Referee's order dated June 20, 1986. In addition, the prior Referee found that claimant was entitled to reimbursement of certain medical expenses and associated penalties and attorney fees. An appeal concerning the prior Referee's order is currently pending before the Court of Appeals.

Applying the law in effect at the time of the deceased worker's 1976 "injury", the insurer paid $1,000 toward the deceased's funeral expenses. Claimant requested a hearing, contending that the current version of ORS 656.204(1) should be applied, thereby granting her maximum burial expenses of $3,000.

We agree with the Referee that the law in effect at the time of injury applies. Since the claimant's claim was for occupational disease, the date of the last exposure is the "date of injury." Johnson v SAIF, 78 Or App 143 (1986). Inasmuch as the date of the deceased worker's last exposure was 1976, the law in effect at that time applies. The version of ORS 656.204 (1) in effect in 1976 provided for a maximum of $1000 for funeral expenses if death resulted from a compensable injury. Therefore, we affirm that portion of the order which found that claimant is entitled to $1,000 in funeral expenses.

The Referee further held that the medical benefits found compensable by the prior Referee's order were not payable pending review under ORS 656.313. The Referee apparently relied on the current version of ORS 656.313 (4). We disagree.

At the time of the deceased's 1976 compensable injury, medical benefits constituted compensation and could not be stayed pending appeal. See SAIF v. Matthews, 55 Or App 608 (1982). Accordingly, we conclude that the insurer was obligated to pay the medical benefits pursuant to the prior Referee's order, pending review of that order. Futhermore, we find the insurer's failure to pay the medical benefits unreasonable. Consequently, a penalty and an attorney fee shall be assessed.

ORDER

The Referee's order dated February 5, 1987 is affirmed in part and reversed in part. The insurer is directed to pay the medical benefits payable by virtue of the prior Referee's order. In addition, the insurer is assessed a penalty, equal to 25 percent of the aforementioned benefits, and a reasonable attorney fee of $500. The remainder of the Referee's order is affirmed.

OLIVE J. ELWOOD, Claimant
Ackerman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-04202
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of those portions of Referee T. Lavere Johnson's order that: (1) awarded nearly five years of additional temporary disability benefits beyond a Determination Order's award; and (2) awarded claimant 100 percent (320 degrees) unscheduled permanent disability for her psychological condition. Should the Board find that claimant was medically stationary prior to the date found in the Determination Order, SAIF requests permission to offset allegedly overpaid temporary total disability benefits. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to award further temporary disability benefits; (2) declined to assess penalties and attorney fees for SAIF's alleged unreasonable refusal to pay retrospective temporary disability benefits; and (3) allowed SAIF to offset some temporary disability benefits. Should the Board decide that claimant is not entitled to additional temporary disability benefits beyond that awarded by the Determination Order, claimant argues that SAIF is, nonetheless, not entitled to an offset. The issues are temporary disability, extent of unscheduled permanent disability, offset, and penalties and attorney fees.

Claimant was discharged from her job as a registered nurse in April 1976. Thereafter, outside of a few unsuccessful self-employment endeavors, she never returned to work. On August 2, 1980, she filed an occupational stress claim that was eventually found compensable in Elwood v. SAIF, 298 Or 429 (1985) on remand 72 Or App 771. Thereafter, SAIF paid temporary disability benefits retroactively from April 15, 1981 until the issuance of a Determination Order in March 1986. In submitting the claim for closure, SAIF specifically requested permission "to recover overpayment, if any, from permanent disability award." The Determination Order found that claimant became medically stationary on October 7, 1980. Accordingly, it awarded claimant temporary disability benefits from August 18, 1980 through October 7, 1980. Inasmuch as no permanent disability was awarded, however, SAIF's requested offset was not mentioned.

The medical evidence concerning the proper medically stationary date is divided. Dr. Holland, psychiatrist, examined claimant on October 7, 1980 and found that her symptoms had entirely abated. Accordingly, Holland considered claimant medically stationary at that time. Dr. Radmore, claimant's treating psychiatrist, examined her in December 1985 and stated, in part:

> "Because of the impression still that there is a possibility for improvement as far as her depression is concerned, [claimant] was advised to remain off antidepressant medication for approximately three weeks * * *."

In February 1986, Radmore stated that claimant was "psychiatrically stationary." Finally, in August 1986, Radmore opined that claimant had never improved since 1976.

Claimant credibly testified that she was unable to work at any job in the competitive labor market because of her ongoing mental state. Dr. Klein, psychiatrist, examined claimant in October 1985 and found no evidence of anxiety or depression. According to Klein, there was no basis for claimant's assertion that she could not work. Dr. Holland rated claimant's permanent psychiatric impairment as "minimal," and concluded her vocational impairment was not nearly as great as she portrayed. Dr. Radmore, however, opined that claimant would never "be able to return to work in any meaningful capacity."

The Referee deferred to the opinion of Dr. Radmore regarding the date in which claimant became medically stationary. Accordingly, the Referee awarded temporary disability benefits from April 15, 1981, the date of Radmore's first examination, to February 11, 1986. Regarding the extent of claimant's unscheduled permanent disability, the Referee concluded that "but for" claimant's lack of motivation, she would be entitled to permanent total disability. Consequently, the Referee awarded claimant 100 percent unscheduled permanent partial disability. We disagree and modify.

Claimant argues that Elwood, supra, requires "as a matter of law" the payment of temporary disability beginning April 1, 1976. However, Elwood dealt solely with the issue of compensability. Inasmuch as SAIF's denial was still in effect, the issue of claimant's entitlement to temporary total disability was not ripe until the claim was determined to be compensable. See Botefur v. City of Creswell, 84 Or App 627, 630 (1987). Further, we do not find that SAIF acted unreasonably in declining to pay temporary total disability back to April 1, 1976. Accordingly, penalties and attorney fees are not appropriate.

Next, we must determine on what date claimant's temporary total disability benefits should have commenced. On August 18, 1980, Dr. Smulovitz, endocrinologist, reported that claimant was unable to work. We interpret Smulovitz's report as indicating claimant was disabled on that date. ORS 656.210; Botefur, 84 Or App at 630-31. Accordingly, temporary total disability benefits were payable beginning August 18, 1980.

ORS 656.005(17) provides: "'Medically stationary' means

that no further material improvement would reasonably be expected from medical treatment, or the passage of time." In our view, the preponderance of the evidence indicates that claimant became medically stationary on October 7, 1980. On that date, Dr. Holland examined claimant and found that, by her own admission, her symptoms had entirely abated. That is also the date the Evaluation Division determined that claimant became medically stationary. It is claimant's burden to prove that the preponderance of the evidence indicates a different medically stationary date. Due to the complex nature of claimant's condition, we view the resolution of the precise date in which she became medically stationary as largely a medical question. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

Here, the only medical evidence contravening Holland's opinion is that of Dr. Radmore. However, Radmore never stated that claimant had not become medically stationary prior to February 11, 1986. Rather, she only stated that inasmuch as the question of further improvement was "moot," claimant was psychiatrically stationary on that date. Moreover, Radmore later stated that despite years of therapy, claimant's condition had "not improved." Accordingly, Radmore's opinion can be seen as, in fact, supporting the view that in October 1980 further medical treatment did not materially improve claimant's condition. On this record, we are unpersuaded by Radmore's contradictory and confusing opinion.

We now turn to the issue of extent of claimant's unscheduled permanent disability. In rating the extent of unscheduled permanent disability for claimant's psychological condition, we consider impairment of the whole person as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Here, claimant is 57 years of age and has a long work history as a registered nurse. Since her job termination, she has refused concrete job offers to work as a nurse, a home health care provider, and a secretary. She testified that she felt unable to return to work in any capacity outside of self-employment:

> "Well, like I -- there is -- I can do it at my leisure, and I'm not underneath that pressure to perform and to go to work every day and to be there on time and to work all day and -- and all the responsibilities that go with work."

Drs. Klein and Holland found no impairment and minimal impairment, respectively. Furthermore, neither doctor recommended any work restrictions. Dr. Radmore, however, opined that claimant would never be able to return to work in any meaningful capacity inasmuch as her psychological condition had not improved.

Exercising our independent judgment in light of the medical record, we find that claimant's impairment of the whole person is in the minimal range. Following our de novo review of lay and medical evidence, including claimant's credible testimony, and considering the relevant social and vocational factors, we

conclude that an award of 15 percent unscheduled permanent disability adequately compensates claimant for her permanent loss of earning capacity due to the compensable psychological condition.

Lastly, we turn to SAIF's request for an offset of allegedly overpaid temporary total disability benefits. Claimant apparently argues that notwithstanding an overpayment, SAIF is nonetheless not entitled to an offset because it did not request the Evaluation Division to reconsider its "determination" pursuant to ORS 656.268(3). We are not persuaded by claimant's argument.

ORS 656.268(3) provides, in part:

> "The Evaluation Division shall reconsider "determinations made pursuant to this subsection whenever one of the parties makes request therefor and presents medical information regarding the claim that was not available at the time of the original determination was made. However, any such request for reconsideration must be made prior to the time a request for hearing is made pursuant to ORS 656.283."

Here, SAIF specifically requested the Evaluation Division to authorize an overpayment against an award of permanent disability. However, inasmuch as the March 1986 Determination Order did not award any permanent disability, there was nothing to authorize an offset against. Accordingly, the Determination Order contained no language concerning an offset.

In our view, the absence of any language concerning an offset is not, by implication, a "determination" under ORS 656.268(4). The Evaluation Division neither approved nor disapproved of SAIF's requested offset. Inasmuch as there was no "determination" with respect to SAIF's requested offset, it was not incumbent upon SAIF to request reconsideration. Therefore, SAIF is entitled to offset temporary total disability paid for the period from April 15, 1981 through March 20, 1986. Forney v. Western States Plywood, 66 Or App 155, 159 (1983).

ORDER

The Referee's order dated October 27, 1986 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant temporary total disability benefits is modified. Claimant is awarded temporary total disability benefits from August 18, 1980 through October 7, 1980. That portion of the Referee's order that awarded claimant permanent partial disability is modified. In lieu of the Referee's award, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability. Claimant's attorney's fee shall be adjusted accordingly. The SAIF Corporation is granted an offset of temporary total disability benefits paid from April 15, 1981 through March 20, 1986, against any unpaid or future awards of permanent disability on this claim. All remaining portions of the Referee's order are affirmed.

JOSEPH H. FISHER, Claimant
Callahan, Hittle, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-01095
October 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of Referee Michael Johnson's order that set aside its partial denial of claimant's bilateral carpal tunnel syndrome. The issue is compensability. We reverse.

Claimant, 60 years old at the time of hearing, was compensably injured in June 1979, when a roll of carpet fell from an overhead rack striking his right neck, shoulder and face. Following the accident, claimant experienced a variety of complaints including pain extending across both shoulders, continuing down the inside of his left arm, and radiating into the lower left extremity. He also complained of dizziness and severe headaches.

Claimant's family physician referred him to Dr. Buza, a neurosurgeon. Dr. Buza diagnosed an extradural defect at C6-7. In July 1980, Dr. Buza performed cervical surgery. Post-operatively, claimant complained of continuing pain in the neck, the right shoulder, the lower back, as well as continued dizziness and headaches. As the result of a series of Determination Orders and Stipulations between January 1980 and May 1984, claimant has received 100 percent unscheduled permanent partial disability.

Claimant was diagnosed as having bilateral carpal tunnel syndrome in July 1984. Dr. Buza recommended that carpal tunnel decompression be performed. SAIF refused to authorize the surgery, contending that the need for the surgery was unrelated to claimant's 1979 injury. At hearing, the parties stipulated that SAIF's denial extended not only to the surgery but also to the condition itself.

The Referee impliedly rejected the opinion of Dr. Button, a specialist in surgery of the hand and upper extremity. Dr. Button performed an independent medical examination in December 1985. He believed that claimant's bilateral carpal tunnel syndrome was neither directly nor indirectly related to his accident. He felt the condition was more likely related to claimant's history of diabetes, to peripheral neuropathy, or to bilateral median nerve entrapment.

Dr. Button's report was forwarded to Dr. Buza, who checked a box on a transmittal letter indicating that he concurred with Dr. Button's report. Several months later, in May 1986, Dr. Buza changed his opinion regarding causation. He opined that claimant's carpal tunnel syndrome was "related" to the prior injury. Dr. Buza's new opinion was based upon claimant's history that he did not begin to experience numbness or tingling in his hands until after the 1979 accident. The Referee assumed that the "history" to which Dr. Buza referred consisted not only of current representations by claimant but also included chart note entries commencing shortly after the original accident.

Dr. Snodgrass, a neurologist, also conducted an examination of claimant and his medical record. He concurred with Dr. Button that claimant's carpal tunnel syndrome was not related to his 1979 injury. He based his opinion in part upon a 1981 report from Dr. Anderson, an orthopedic surgeon.

Dr. Anderson's 1981 report noted that claimant's complaints did not extend below the elbows. He expressly stated that claimant

was experiencing no numbness or tingling in either hand. He tested claimant for carpal tunnel syndrome and reported "carpal tunnel test negative."

The Referee expressly rejected Dr. Snodgrass' report based upon the fact that Dr. Snodgrass apparently overlooked a chart note by Dr. Buza in July 1980 which states that claimant was experiencing numbness and tingling in his hands. This chart note was dated eight days following his surgery. It is the only reference throughout this period that contains any express mention of hand or wrist involvement.

As claimant's treating physician, Dr. Buza's opinion would normally be accorded greater weight, absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). This record presents persuasive reasons to discount Dr. Buza's conclusions. Dr. Buza initially concurred with Dr. Button that claimant's bilateral carpal tunnel syndrome was unrelated to his 1979 injury. His change of mind was not based upon any new medical finding but simply upon the fact that claimant experienced no symptoms prior to 1979. The fact that claimant developed his bilateral carpal tunnel sydrome following the 1979 injury is of limited value in determining whether the condition is casually related to the accident. In view of the complexity of claimant's condition and its relationship to his 1979 injury, we consider a well-reasoned and thorough analysis critical to the relative persuasiveness of a physician's opinion. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980).

By contrast, Dr. Button provided three alternative diagnoses, none of which have been refuted. Furthermore, Dr. Anderson expressly stated that, as of 1981, claimant was experiencing no hand or wrist symptoms. Claimant testified at hearing that he experienced continuing hand and wrist problems commencing in 1979. The Referee found claimant to be credible. We note, however, that this case involves complex medical causation issues. While we do not ignore either the Referee's credibility finding or claimant's testimony, we find resolution of these issues largely dependent on expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We conclude that the more persuasive medical testimony opposes a finding of compensability.

Dr. Button suggested that "[c]arpal tunnel syndromes can result in referred pain more proximally." Claimant contends that his complaints of arm and shoulder pain are an example of such a finding. However, Dr. Button attributed claimant's present symptoms to referred pain from claimant's "well documented cervical radiculopathy," not to his bilateral carpal tunnel syndrome. Dr. Buza's opinion that carpal tunnel decompression might relieve some of claimant's shoulder pain is not persuasive.

Compensability must be proven by a preponderance of the evidence. Hutcheson v. Weyerhauser, 288 Or 51, 56 (1979). Claimant has failed to sustain his burden of proof.

ORDER

The Referee's order dated February 12, 1987 is reversed. The SAIF Corporation's partial denial is reinstated and upheld.

JAMES R. GARRISON, Claimant
Garry L. Kahn, Claimant's Attorney
Edward C. Olson, Defense Attorney

WCB 86-14817
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that upheld the insurer's denial of his aggravation claim for a low back condition. The issue is aggravation.

Claimant, 28 at the time of hearing, compensably injured his left elbow, neck, and back in an August 1985 automobile accident. Initially, his condition was diagnosed as a "probable sprain" of the left elbow. Shortly thereafter, however, he felt the onset of neck and back pain without incident or trauma. At that time, he was examined by Dr. Deitchler, a chiropractor. Deitchler apparently took x-rays and diagnosed cervical, thoracic, and lumbar strain with associated radiculopathy into the left lower extremity. While under Deitchler's care, claimant was instructed to perform certain at-home exercises. Although he did not return to Deitchler after September 10, 1985, claimant continued his at home exercises through mid-March 1986. In December 1985, Deitchler released claimant to regular work.

In late October 1985, the Western Medical Consultants performed an independent medical examination. The Consultants reported that claimant was not medically stationary and projected that he could return to regular work in two to three months. According to the Consultants, claimant's permanent impairment, if any, was "minimal."

A Determination Order issued in January 1986 without an award of either temporary or permanent disability. That same month, claimant returned to work as a heating and air conditioning serviceman for a new employer. In March 1986, while at home on a weekend, claimant coughed and immediately felt the onset of severe low back pain. The following morning, he sought treatment from Dr. Leistikow, a chiropractor. Leistikow suspected a possible lumbar disc herniation. Subsequent diagnostic studies revealed a central disc herniation at L4-5.

Claimant was examined by Dr. Grewe, neurosurgeon, in March 1986. Noting that "conservative treatment" had been unsuccessful, Grewe recommended corrective surgery. In November 1986, Grewe performed removal and decompression surgery. Claimant's symptoms largely resolved thereafter. Grewe is of the opinion that the compensable August 1985 injury caused claimant's herniated disc and resulting need for surgery. According to Grewe, the acute symptoms from such an injury initially improve, but then subsequently worsen due to a failure of the disc cartilage to heal.

Dr. Silvers, neurosurgeon, also examined claimant in March 1986. Silvers apparently believed that claimant's March 1986 coughing incident occurred on the job:

> "In my opinion, [claimant] suffered no industrial injury while sitting at his desk at [the latter employer] on March 13, 1986. In my opinion, the proximate worsening of [claimant's] condition, i.e.,

> the reason he has recently sought treatment relates to a cough which did not have anything to do with his work." (Emphasis added).

Dr. Rosenbaum, neurosurgeon, examined claimant in September 1986 for the purposes of an independent medical examination. Rosenbaum found that there was nothing in the medical records that would indicate claimant sustained a "new injury" while at the latter employer. Assuming, however, that claimant had a disc protrusion at L4-5 and ongoing discomfort following his August 1985 injury, Rosenbaum opined that the August 1985 injury "played at least a moderate contribution to [claimant's] symptomatology."

The Referee found that claimant's testimony had been "impeached" by the documentary evidence. Finding Dr. Silvers' opinion as plausible as either that of Drs. Grewe or Rosenbaum, the Referee concluded that claimant had not proven an aggravation claim. We disagree.

We generally defer to the Referee's assessment of credibility when based on the witness' demeanor. Humphrey v. SAIF, 58 Or App 360, 363 (1982); Richard K. Adams, 38 Van Natta 530, 531 (1986). However, when the Referee's credibility finding is based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Andrew Simer, 37 Van Natta 118 (1985).

Here, the Referee stated:

> "Claimant's testimony is suspect. Claimant's testimony indicated that he returned to [the latter employer] and performed light work only, i.e., wiring and checking equipment. His testimony is inconsistent with the job duties discussed, and reported, by [claimant's vocational counselor] on May 23, 1986 * * *. Claimant's testimony indicated that he was never pain free, regarding the low back area, after the industrial injury of August 6, 1985. The documentary evidence suggests the contrary. No active medical treatment was received by claimant after September 10, 1985."

We have examined the vocational counselor's report of May 1986. The report indicates that the vocational counselor understood claimant to state that he lifted steel pipe weighing up to 100 pounds and furnaces weighing up to 200 pounds. Claimant never testified, however, that he did not lift 100 pound steel pipe and 200 pound furnaces. Rather, claimant testified that he was assigned "a helper" because he was unable to lift heavy objects unassisted.

We have also examined claimant's testimony to determine whether he testified that he "was never pain free" following his August 1985 injury. He did not. In fact, claimant testified that in the fall of 1985 his condition temporarily improved with rest. This is entirely consistent with Dr. Grewe's explanation that the

acute symptoms from a torn annulus initially improve before developing into a bulging disc. Moreover, we are unwilling to speculate as to whether an absence of medical treatment from September 1985 to March 1986, is tantamount to an absence of pain during that same period. We note, however, that the Western Medical Consultants indicated that claimant was not pain free in late October 1985 and was not expected to become so until at least two months beyond that date. Further, Dr. Leistikow reported in March 1986 that claimant "has never completely been free of pain since his [August 1985] injury."

After our de novo review of claimant's lay testimony and the documentary evidence, we are not persuaded that claimant has been "impeached." Accordingly, we do not find claimant to be a noncredible witness.

Turning to the merits of claimant's aggravation claim, he must show: (1) a worsening of his condition that made him more disabled (i.e., less able to work) than at the time of the last arrangement of compensation; and (2) a causal relationship between the worsened condition and the compensable August 1985 injury. Stepp v. SAIF, 78 Or App 438 (1986); ORS 656.273(1). Increased symptoms alone do not establish an aggravation claim, unless claimant suffers pain or additional disability that reduces his ability to work thereby resulting in a loss of earning capacity. Smith v. SAIF, 302 Or 396 (1986).

Here, the last arrangement of compensation was in January 1986. At that time, there was no diagnosis or objective evidence of a protruded disc at L4-5. Dr. Deitchler and the Western Medical Associates had diagnosed only "lumbosacral subluxation" or "lumbosacral strain" respectively. Moreover, at that time claimant had returned to his former type of work for the latter employer. After the off-work coughing incident in March 1986, however, a disc protrusion at L4-5 was diagnosed. As a result, claimant was taken off work and eventually underwent surgery in November 1986. He was not released back to work until March 1987. Accordingly, we find that claimant has proven a worsening of his compensable condition that rendered him less able to work.

Drs. Grewe and Rosenbaum feel that the August 1985 injury caused claimant's disc protrusion and resulting need for surgery. We find Grewe's analysis well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). The insurer argues that Grewe had an inaccurate history inasmuch as he reported that claimant had not responded successfully to seven months of "conservative treatment." We disagree with the insurer's argument. Claimant testified that after September 1985 he rested and performed at-home exercises. Those conservative measures did not work, however, and Grewe ultimately recommended surgical intervention. We are not persuaded that Grewe had an inaccurate history.

Dr. Silvers has offered the only medical opinion that does not support claimant's case. However, Silvers mistakenly believed that claimant's March 1986 coughing incident occurred on-the-job. Thus, the tenor of Silvers' opinion focuses on whether claimant sustained a new "industrial injury," not whether the compensable August 1985 injury was a material contributing cause of his protruded disc. We are unpersuaded by Silvers' inaccurate and confusing opinion.

After our de novo review of the lay and medical evidence, we find that claimant has proven a valid aggravation claim.

ORDER

The Referee's order dated April 24, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's denial is reversed. The insurer's denial is set aside and the aggravation claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded a reasonable attorney fee of $1,400 for his services at the hearing and $600 for services on Board review to be paid by the insurer. All remaining portions of the Referee's order are affirmed.

CHARLOTTE D. HAWTHORNE, Claimant
Welch, et al., Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys

WCB 86-06979
October 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Podnar's order that awarded claimant 35 percent (112 degrees) unscheduled permanent partial disability for a neck and left shoulder injury, in lieu of the Determination Order which awarded no permanent disability. On review, the insurer contends that the Referee's award is excessive. We agree and modify.

Claimant was 52 years old at the time of hearing. She has sustained prior compensable and noncompensable injuries. In 1971 she injured her upper back, neck and shoulders in a motor vehicle accident. In 1975, while working for a previous employer, she again injured her back and shoulder. This injury resulted in a 15 percent unscheduled permanent partial disability award. Claimant reinjured her right shoulder and neck in June 1977, while working for another previous employer. She received a total of 25 percent unscheduled permanent partial disability as a result of this injury.

In October 1983 claimant filed a claim with the present employer for neck and shoulder pain. Following litigation, the claim eventually was found compensable.

In September 1984 Dr. Platt, claimant's current treating neurologist, opined that claimant suffered from a continuation of the same process that had been arising frequently since 1971. Although claimant had some relatively asymptomatic periods, Dr. Platt stated that she suffered from a chronic low grade upper back and shoulder ache. Concluding that claimant's physical impairment was quite minimal, Dr. Platt attributed no impairment to claimant's October 1983 compensable injury.

A January 30, 1985 Determination Order awarded no permanent partial disability. Claimant requested a hearing.

In January 1986 Dr. Platt opined that claimant was capable of performing light to sedentary work on a part time basis. He concluded that claimant's overall impairment was mildly moderate. In March 1986 Dr. Fry concluded that claimant was unable to return to any type of work which required repetitive arm activities, or lifting more than 20 pounds at a time.

In July 1986 Dr. Duff, orthopedist, performed an independent medical examination. Noting that x-rays revealed a very mild disc narrowing at C5-6, Dr. Duff concluded that much of claimant's problems were chronic and related to her several previous neck injuries. He agreed that claimant was unable to perform overhead work with her left arm or to engage in heavy lifting. Describing claimant's physical impairment as "quite minimal," Dr. Duff attributed claimant's restrictions to her preexisting problems and not the October 1983 compensable injury.

In December 1986 Dr. Platt opined that claimant could sit for two hours consecutively and for a total of four hours in a work day. In addition, Dr. Platt felt that claimant could stand and walk for one hour each consecutively and for a total of two hours in a work day. Claimant was able to frequently lift five pounds and occasionally lift and carry ten pounds. Dr. Platt concluded that claimant's total impairment for all her injuries was mildly moderate to moderate.

At the time of the hearing, claimant was working four hours a day as a postmaster. She had problems with her left shoulder and arm, as well as neck pain after sitting with her head bent forward. Claimant has a high school education. Her work experience includes waitressing, bartending, and bookkeeping. In addition, claimant has owned a grocery store and worked in electronic assembly.

The Referee conceded that there were medical opinions relating claimant's problems to her past injuries. However, the Referee reasoned that it was apparent that her disability had increased as a result of the 1983 compensable injury. After taking into consideration social and vocational factors, as well as claimant's prior awards, the Referee concluded that claimant had experienced a 35 percent loss of earning capacity as a result of this injury. We disagree.

The criteria for rating extent of unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5); Barrett v. D & H Drywall, 300 Or 553, 555 (1986). Earning capacity is the ability to obtain and hold gainful employment taking into consideration age, education, training, skills and work experience. ORS 656.214(5); see also OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Furthermore, should a further accident occur to a worker who is receiving compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities. ORS 656.222. The statute prescribes that compensation for permanent disability awarded shall be counted in an award for a later accident. Norby v. SAIF, 303 Or 536, 540 (1987). However, a mechanical offset is not required. Thomason v. SAIF, 73 Or App 319, 322-23 (1985).

Following our de novo review of the medical and lay testimony, including the Referee's reference to claimant's positive motivation, we are persuaded that claimant is entitled to an award of unscheduled disability. However, we find the Referee's award to be excessive. After completing our review and considering the above mentioned points and authorities, we conclude that an award of 20 percent unscheduled permanent disability adequately compensates claimant for her compensable injury.

ORDER

The Referee's order dated February 19, 1987 is modified. In lieu of the Referee's award and and in addition to the January 30, 1985 Determination Order, claimant is awarded 20 percent (64 degrees) unscheduled permanent partial disability for her compensable neck and shoulder condition. Claimant's attorney's fees shall be adjusted accordingly.

JAMES R. HILDERBRAND, Claimant
Charles D. Maier, Claimant's Attorney
Malagon & Moore, Claimant's Attorneys
Les Huntsinger (SAIF), Defense Attorney

WCB 85-15943
October 19, 1987
Order on Reconsideration (Remanding)

Claimant has requested reconsideration of our Order on Review dated August 26, 1987 that affirmed Referee Nichols' order that held, among other findings, that claimant's neck and left shoulder condition was not related to his October 1979 compensable low back injury. Specifically, claimant has asked that this case be remanded to the Referee for consideration of a post-hearing medical report. On September 22, 1987, we abated our order to consider claimant's request and SAIF's response.

The post-hearing report concerns an opinion from Dr. Henbest, a neurosurgeon, who recently performed cervical surgery. Dr. Henbest had apparently neither examined claimant nor commented on his condition prior to the hearing. Following the surgery, Dr. Henbest diagnosed "cervical spondylosis with osteophytic processes causing compression of the nerve roots." Based on observations made during the surgery, Dr. Henbest opined that the osteophytes had been present for "quite some time." However, he conceded that he could not identify the time of their formation. Dr. Henbest concluded that it "seem[ed] reasonable to believe that the osteoarthritis was exacerbated, if not started by a significant injury to the head or neck."

Contending that the only significant injury to his head or neck was his October 1979 compensable injury, claimant asks that this matter be remanded to the Referee for consideration of Dr. Henbest's post-hearing report. The request is granted.

Inasmuch as the surgery was performed post-hearing, the proferred evidence was obviously unobtainable at the time of the hearing. Moreover, although the present record contains several medical opinions concerning this issue, the surgery report offers a particularly unique perspective on the question of whether a causal relationship exists between claimant's current neck condition and his October 1979 compensable injury.

We are mindful that the workers' compensation scheme requires not only promptness but also finality in the decision making process. Compton v. Weyerhaeuser Co., 301 Or 641, 649 (1986). Furthermore, considering the Referee's analysis, it is possible that the impact of this additional evidence will be minimal. However, the post-hearing surgery report is probably not cumulative and could contain relevant evidence not previously available to support claimant's medical service claim. Therefore, we find that consideration of this evidence might well create a reasonable likelihood that the outcome of this case would be affected. See Cain v. Wooley Enterprises, 301 Or 650, 654 (1986).

Under these circumstances, we conclude that the record has been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(5). Consequently, we remand this case for further development in light of the post-hearing surgery report. After reviewing the surgeon's opinion and evidence offered by SAIF in rebuttal, the Referee is instructed to issue an Order on Remand discussing the effect, if any, the additional evidence has had upon the findings rendered in her prior order.

ORDER

The request for reconsideration is granted and our former order withdrawn. The Referee's order dated October 30, 1986 is vacated and this case is remanded to Referee Nichols for further action consistent with this order.

CLAY E. HUGHES, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 86-00869
October 19, 1987
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's occupational disease claim for a low back condition; and (2) set aside its "de facto" denial of claimant's travel and lodging expenses incurred while attending an independent medical examination. The issues are compensability and reimbursement for the aforementioned expenses.

Claimant, 61 years of age at the hearing, has worked approximately 28 years for the employer as a rigger. The job is performed in the woods and involves heavy physical work. During the course of his employment, claimant has experienced several low back strains. In 1957 and 1961, he injured his low back, but sought no medical treatment and lost no time from work. In 1973, he strained his low back and was placed on light duty work for four days. In November 1980, he sought chiropractic treatment for a minor low back sprain. After four days of treatment, his condition returned to its "pre-injury state."

In June 1983, claimant sustained a compensable left knee injury, which resulted in two menisectomy operations. Thereafter, he alleged low back pain as a result of an altered gait from his knee injury. The employer issued a partial denial of the low back condition, which was upheld by a prior Referee. The order was not appealed.

A Determination Order issued in January 1985, awarding 30 percent scheduled permanent disability for loss of use of the left leg (knee). In March 1985, claimant returned to work for the employer as a shop helper. Shortly thereafter he retired.

In July 1985, claimant filed an occupational disease claim for "accelerated degenerative problems in my lumbar spine." A few months later, the employer sent claimant a notice of an independent medical examination along with a check in the amount of $84.00 for "travel expense." The medical examination was scheduled for 1:45 p.m. in Portland, Oregon. Claimant, a resident of Coos Bay, Oregon, traveled to and from Portland. After completion of the medical examination, he ate dinner at a restaurant and spent the night in a Portland hotel. The next

morning, he ate breakfast in Portland before returning home. Claimant seeks reimbursement for his mileage, lodging, and two meals. The Referee apparently took official notice that the round trip travel distance between Coos Bay and Portland was 424 miles.

In November 1985, claimant was examined by Dr. Zivin, neurologist. Zivin diagnosed musculoligamentous strain in the right buttock and degenerative disc disease. According to Zivin, claimant's disc degeneration was "entirely consistent with [his] age * * *." Zivin concluded that it was not possible to ascribe the onset of claimant's low back symptoms to one isolated contributing factor. In June 1986, Dr. Whitney, orthopedist, was asked to review certain medical records and sign the following statment:

> "I concur that [claimant's] long-term employment at [the employer] is the major contributing cause of his mild degenerative disc disease and low back condition."

Rather than sign the above quoted statement, Whitney provided his own report, stating, inter alia:

> "In general, I feel his work activities and his several back strain injuries probably had some significant cause of his current back degeneration. In addition, his gait problem with his knee has shown a significant alteration causing an additional strain to the back. * * * Retrospectively, looking at [claimant], I feel that his work activities being of a physical nature are a significant cause of his back degeneration."

Claimant testified that his non-work activities included bowling, fishing, and loading firewood. He has not bowled since 1983, however, and he loads firewood with the assistance of his wife.

Although the Referee interpreted Dr. Whitney's report as "unfavorable," he nonetheless found that claimant had established an occupational disease claim. We disagree.

To establish a claim for an occupational disease, claimant must prove that his work exposure was the major contributing cause of his condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). Because his degenerative disc disease preexisted his employment, claimant must also prove that his work exposure was the major cause of a worsening of his underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). Inasmuch as the etiology of claimant's accelerated disc degeneration is largely a complex medical question, we find that the resolution of this case is largely dependent on expert medical opinion. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, Dr. Zivin found that x-ray findings of claimant's disc degeneration were entirely consistent with his age. He further stated that it was not possible to conclude that claimant's work activities were the major contributing cause of his disc degeneration. Likewise, Dr. Whitney refused to state that claimant's work activities were "the major contributing cause" of his disc degeneration or low back condition. Thus, in our view, Whitney's opinion must be viewed as stating that claimant's work activities were something less than "the major contributing cause" of his disc degeneration or worsening

thereof. Although we realize that "magic words" are not a condition precedent to proving compensability, we are not persuaded, on this record, that the evidence preponderates in favor of compensability. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Lastly, we turn to the question of reimbursement for claimant's travel and lodging expenses incurred while attending an independent medical examination. Claimant has submitted receipts showing that he spent $27.00 for one night's lodging and $14.10 for two meals. He seeks reimbursement for those expenses, as well as 498 miles of travel at .20 cents per mile. The employer "vehemently" contends that OAR 436-60-070 controls the applicable rate of reimbursement. The Referee utilized the rate of reimbursement in a collective bargaining agreement for certain Oregon public employees and awarded claimant an additional $44.40. We disagree.

OAR 436-60-070(2)(b) states that travel and lodging expenses incurred while seeking medical treatment or collecting compensation benefits shall be reimbursed at the prevailing rate for State of Oregon classified employes. However, the preceding section, OAR 436-60-070(1), makes it clear that OAR 436-60-070(2)(b) applies only to accepted claims. Here, at the the time of claimant's independent medical examination, his claim had been neither accepted nor denied.

OAR 436-60-090(f), on the other hand, pertains to independent medical examinations and provides, in part:

> "that reasonable cost of public transportation or use of a private vehicle will be reimbursed and that when necessary, reasonable cost of meals, lodging and related services will be reimbursed."

Exercising our independent judgment, reimbursement for 424 miles of travel at .20 cents per mile, one night's lodging at $27.00, and two meals totaling $14.10, are reasonable and necessary expenses under OAR 436-60-090(f).

ORDER

The Refereee's order dated August 28, 1986 is modified in part and reversed in part. In lieu of the Referee's award of additional travel reimbursement, the employer is directed to reimburse claimant for $41.90. The self-insured employer's denial of January 13, 1986 is reinstated and upheld.

Board Member Lewis, dissenting:

I respectfully dissent on the issue of compensability.

Claimant has worked nearly 30 years for the employer and has suffered several low back strains while at work. He has no history of back complaints prior to his employment and there is no non-work exposure that would explain his accelerated disc degeneration. Although the medical evidence is divided, I am persuaded by the well reasoned opinion of Dr. Whitney, claimant's treating physician. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Weiland v. SAIF, 64 Or App 810 (1983).

The majority found Dr. Whitney's opinion unpersuasive, in part, because he did not sign a letter from claimant's attorney that contained the necessary "magic words." However, in previous cases, we

have held that a conclusory medical opinion is unpersuasive. David A. Wilson, 39 Van Natta 21, 22 (1987); Lisa V. Protho, 39 Van Natta 141, 144 (1987). Here, Dr. Whitney chose to explain his opinion in his own words, rather than simply sign a conclusory statement authored by claimant's attorney. In my view, this made Dr. Whitney's opinion more persuasive, not less persuasive.

In McClendon, supra, as here, the medical evidence was divided. The claimant's treating physician failed to use "magic words," but did state that the claimant's right shoulder condition was "due to or aggravated by her occupation." The McClendon court found that when the treating physician's opinion was juxtaposed with the fact that claimant had performed repetitive arm movements only at work, compensability was established. 77 Or App at 417.

Here, the evidence is even more compelling towards compensability than in McClendon. First, Dr. Whitney stated that degenerative disc disease can be increased by multiple traumas over a period of time. Ultimately, Dr. Whitney concluded that claimant's work activities were "a significant cause of his back degeneration." Second, claimant suffered many low back traumas only at work. Last, claimant performed regular heavy physical labor only at work.

Accordingly, the preponderance of the evidence establishes that claimant's work activities were the major contributing cause of his disc degeneration, or its worsening.

ARTHUR G. JENNINGS, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-11312
October 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of that portion of Referee St. Martin's order that assessed a penalty and attorney fee for failing to timely pay an initial installment of temporary disability. In its brief, claimant requests review of that portion of the Referee's order that declined to assess penalties and attorney's fees for SAIF's failure to timely pay subsequent installments of temporary disability. On review, the issues are penalties and attorney fees.

Pursuant to a prior Referee's order dated April 16, 1986, SAIF paid an initial installment of temporary disability on April 30, 1986. SAIF subsequently paid the two remaining installments on May 14, 1986 and May 28, 1986. None of the installments included payment for the seven-day period preceding and including the date of payment.

In support of its conduct, SAIF relied on OAR 436-60-150(4). The relevant portion of this rule reads: "(c)ontinued temporary disability due shall be paid within 7 days of the date of payment at least once each 14 days thereafter."

The Referee assessed a 25 percent penalty based on the one week of compensation not included in the initial installment and ordered SAIF to pay claimant's attorney a $750 attorney fee. He did not assess a penalty and attorney fee for the second and third installments.

On review, claimant argues that the retention of temporary disability benefits authorized by OAR 436-60-150(4) violates the workers' compensation law. Accordingly, he contends that SAIF was unreasonable in relying on the rule and should be assessed penalties

and attorney fees for the late payment of temporary disability. Alternatively, even if SAIF was not unreasonable in relying on the rule in regard to the second and third installments, claimant argues that the rule does not authorize retention of temporary disability benefits from initial installments of temporary disability.

On review, SAIF contends it reasonably relied on OAR 436-60-150(4) and should not be assessed penalties and attorney fees for retaining benefits in either its initial or later installments.

The Board has held that it is without authority to determine the validity of an administrative rule. James R. Frank, 37 Van Natta 1555, 1557 (1985). Accordingly, we do not address claimant's contention that OAR 436-60-150(4) violates workers' compensation statutes. Furthermore, in reaching our decision, we do not find it necessary to interpret the language of OAR 436-60-150(4). Rather, our inquiry is limited to whether SAIF's interpretation of that rule was reasonable.

Recent Board decisions issued subsequent to the Referee's order have found that it is reasonable for an insurer to retain subsequent temporary disability payments in reliance on OAR 436-60-150(4). See Catherine A. Medina, 39 Van Natta 384 (1987); Billy A. Springs, 38 Van Natta 1475 (1986). Consequently, we affirm that portion of the Referee's order that declined to assess penalties and attorney fees in regard to the second and third installments.

The Board decisions discussed above did not concern initial installments of temporary disability. In John Keller, 38 Van Natta 1351 (1986), the Board declined to penalize an insurer for similar retentions in both initial and subsequent installments. However, the distinction raised here was not specifically addressed by the Board. As a result, we do not find Keller to be controlling.

After a de novo review of the record, we find that SAIF reasonably interpreted OAR 436-60-150(4) as applying to both initial and later installments. Accordingly, we reverse that portion of the Referee's order that assessed a penalty and attorney fee for SAIF's failure to timely pay the initial installment of temporary disability.

ORDER

The Referee's order dated November 4, 1986 is affirmed in part and reversed in part. That portion of the order that assessed the SAIF Corporation a penalty and associated attorney fee for a failure to timely pay an initial installment of claimant's temporary disability is reversed. The remainder of the Referee's order is affirmed.

JAMES L. LANCE, Claimant
Steven Yates, Claimant's Attorney
Kevin Mannix, Defense Attorney
Davis, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
Garrett, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Richard Butler, Attorney
Dean Sandow, Attorney
Marcus Ward, Attorney
Gary Jones, Attorney
Schwabe, et al., Attorneys
Mitchell, et al., Attorneys
David Horne, Attorney
William Beers, Attorney
Roberts, et al., Attorneys

WCB 86-00279, 86-05948, 86-05102, 86-05103, 86-05104, 86-05105, 86-05106, 86-05107, 86-05108, 86-05109, 86-05110, 86-05111, 86-05112, 86-05113, 86-05114, 86-05115, 86-05116, 86-05117, 86-05118, 86-05119, 86-05120, 86-05121, 86-05122, 86-05123 & 86-05124

October 19, 1987
Order of Abatement

Standard Fire Insurance Company (Standard Fire) requests reconsideration of our October 8, 1987 Order on Review that affirmed the Referee's finding that it was responsible for claimant's left knee claim. Relying on the reasoning expressed in Runft v. SAIF, 303 Or 493 (1987), we concluded that since Standard Fire had not joined claimant's subsequent employers, it could not assert the last injurious exposure rule defensively to defeat claimant's claim.

Standard Fire asserts that it chose not to join the subsequent employers in reliance on the Court of Appeals' decision in Runft v. SAIF, 78 Or App 356 (1986), which had indicated that the last injurious exposure rule could be used defensively under these circumstances. Inasmuch as the Court of Appeals' decision was reversed by the Supreme Court after the hearing in this case, Standard Fire contends that this matter should be remanded to the Referee to allow it an opportunity to join claimant's subsequent employers.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the parties are requested to file a response to the motion within 21 days. Thereafter, the Board will take the request for remand under advisement.

IT IS SO ORDERED.

JANET E. LONG, Claimant
Royce, Swanson & Thomas, Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys

WCB 86-6429
October 19, 1987
Order on Reconsideration

Reviewed by Board Members McMurdo and Lewis.

Claimant has requested reconsideration of the Board's September 29, 1987 Order on Review that: (1) set aside the insurer's denial of claimant's medical service claim for a jacuzzi and recliner chair; (2) awarded an insurer-paid attorney fee of $800 for services at the hearing and on Board review concerning the medical service issue; and (3) affirmed the Referee's finding that penalties and attorney fees were not justified for allegedly improper claims processing.

Claimant asks that we clarify that the $800 has been awarded to his attorney. The request is granted. Consequently, our order is modified to reflect that claimant's attorney is awarded an insurer-paid fee of $800 for services rendered at the hearing level and on Board review concerning the medical service issue.

In addition, claimant seeks an increase in his attorney fee award. He suggests that an appropriate fee for his counsel's efforts at both levels would be $1,600.

Where claimant finally prevails in a hearing before the Referee or in a review by the Board, the Referee or Board shall allow a reasonable attorney fee. ORS 656.386(1). Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained. In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss these factors should not be taken to mean that they were not carefully considered in determining a reasonable attorney fee. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

In determining claimant's attorney fee award, the aforementioned points and authorities were fully considered. On reconsideration, we continue to find that an $800 attorney fee for services at the hearing level and on Board review concerning the medical service issue is reasonable.

Finally, claimant asks that we address the "improper claim processing" issue. Claimant accurately asserts that the body of our order failed to discuss this matter. However, our order concluded by stating that the remainder of the Referee's order was affirmed. After further review of this issue, we continue to find that the insurer's conduct was not unreasonable under the circumstances. Consequently, we conclude that penalties and attorney fees are not warranted.

Accordingly, claimant's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as modified and supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

ROBERT L. PIEPER, Claimant
Cash R. Perrine, Claimant's Attorney
Cowling & Heysell, Defense Attorneys
Davis, et al., Defense Attorneys

WCB 85-15930 & 86-6073
October 19, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of T. Lavere Johnson's order that: (1) upheld EBI Companies' partial denial of his claim for neck, low back, and psychological conditions; (2) upheld a Determination Order's finding that claimant's compensable August 1983 right shoulder injury became medically stationary on February 14, 1984; (3) approved EBI's request for an offset of temporary disability benefits; and (4) found that his claim for neck, upper extremities, and back conditions against Loggers' Assurance Company was time-barred. Loggers cross-requests review of that portion of the Referee's order that found claimant had proven a compensable claim against it, but for, his failure to provide timely notice of a claim. The issues are compensability, the correct medically stationary date, offset, and timeliness.

Claimant, 51 at the time of hearing, has a long history of head, neck, and back problems. In 1964, he injured his low back apparently resulting in surgery. Thereafter, he returned to regular work as a truck driver despite continuing intermittent low back pain. In 1975, he suffered a blow to the head and was treated conservatively for approximately six months. The record is unclear as to whether those two injuries were industrially related. In 1979, while working for a former employer, claimant sustained a compensable injury to his head, neck, right shoulder, and low back. Shortly thereafter, a Determination Order closed his claim with an award of 15 percent unscheduled permanent disability. In October 1980, his claim was reopened for a lumbar laminectomy and discectomy performed by Dr. Kendrick, surgeon. After conservative treatment, he returned to truck driving in May 1981. An October 1981 Determination Order reclosed his claim with an additional award of 15 percent unscheduled permanent disability.

Claimant worked without difficulty until August 1983, when a wrench struck his head and right shoulder. At that time, the employer was insured by EBI. On the initial 801 claim form, claimant reported that his "right shoulder" was injured. Shortly thereafter, claimant was examined by Dr. Kendrick for neck and right shoulder pain. Kendrick referred claimant to Dr. Sulkosky, emergency room physician. In September 1983, Sulkosky reported that claimant was continuing to experience neck pain and prescribed a cervical collar. Later that month, Dr. Kendrick reexamined claimant and noted the development of suboccipital headaches.

In October 1983, claimant reinjured his low back in a slip-and-fall accident at home. Dr. Kendrick hospitalized claimant and diagnosed lumbar disc disease, stating (in part):

> "The [claimant] had been injured in an industrial accident and had lumbar disc injury. He underwent a laminectomy and * * * posterolateral fusion by myself and Dr. Sulkosky which was quite successful and the [claimant] has done quite well with respect to his back. Several days ago he fell * * * and has had marked increase in low back pain * * *."

After a short stay in the hospital, an arthrogram was performed on claimant's right shoulder revealing a rotator cuff tear. Consequently, Dr. Sulkosky performed rotator cuff repair surgery in November 1983. Claimant was rehospitalized in February 1984 for a cervical myelogram. The myelogram revealed narrowing at C5-6 and bilateral defects at C4-5 through C6-7. Thereafter, Sulkosky opined that claimant would have "continued problems with his neck."

In March 1984, claimant was examined by Dr. Kendrick. Kendrick found that claimant "continues to have no trouble with his low back." Consequently, Kendrick released claimant back to regular work.

In May 1984, claimant returned to work as a truck driver for the employer. At that time, the employer was insured by Loggers. Claimant was apparently assigned a truck that was not

equipped with an air seat. According to claimant's testimony, his back began hurting while traveling to work:

> "Q. What do you mean you knew you weren't going to make it?
>
> "A. Well, I -- I kept having these pains in my low back and my left leg, and --.
>
> "Q. Was that even before you started driving?
>
> "A. Oh, yes, on the way over there in my car or pickup, I had a lot of troubles. I can't remember whether I had the car or pickup.
>
> "Q. And how long did you work that day?
>
> "A. Ten hours."

Shortly thereafter, claimant returned to Dr. Kendrick. Kendrick noted that claimant had driven a truck with a "hard seat" for 10 hours and had experienced marked neck and low back pain. Kendrick concluded that that claimant's condition had "clearly been aggravated by his recent experience."

In August 1984, Dr. Kendrick referred claimant to Dr. Dimitman, psychiatrist. Dimitman reported that he had seen claimant "on an emergency basis on 8/29/84 because of depression and overdosing with suicidal intent." Dimitman treated with regular psychotherapy and antidepressant medication. A few months later, Dimitman reported that claimant had improved with respect to his suicidal ideation, but had continued to evidence poor self esteem "some of which related to his physical disability."

Dr. Kendrick reexamined claimant in October 1984, and reported, in part:

> "I think [claimant's] most recent injury certainly has contributed to his present problems since he seemed to be getting along reasonably well before the accident."

Subsequently, Dr. Kendrick diagnosed a dislocated rod in claimant's lower back and performed removal surgery in June 1985.

In December 1985, EBI issued a partial denial of claimant's neck, low back, and psychological conditions. After receiving EBI's denial, claimant filed a new claim for the same conditions against Loggers in January 1986. Loggers denied the claim in April 1986, on the basis of timeliness and compensability.

In January 1986, Dr. Kendrick referred claimant to Dr. Herz, psychiatrist, for "reactive depression based on his injury and the disability attendant to that." A few months later, Herz diagnosed, in part: "Major Depression associated with Chronic Pain Syndrome."

A Determination Order issued in March 1986 awarding claimant an additional 10 percent unscheduled disability. However, the Determination Order did not rate any of the conditions denied by EBI.

The Referee found that claimant's testimony concerning the August 1983 injury, was inconsistent with the documentary evidence. Consequently, he upheld EBI's partial denial. The Referee went on to find that the 10 hours of truck driving in May 1984 for Logger's insured, had materially contributed to claimant's current condition. However, inasmuch as the Referee found that claimant had not provided timely notice of an injury to Logger's insured, he upheld Logger's denial. We disagree.

We find claimant's current neck condition is related to his compensable August 1983 injury. His low back and psychological conditions, however, are not compensable.

EBI denied compensability, rather than merely medical services, of claimant's neck, low back, and psychological conditions. Therefore, in order to establish compensability against EBI, claimant must show that the August 1983 injury materially contributed to one or all of the aforementioned conditions.

Loggers denied compensability of claimant's neck, low back, and psychological conditions on the basis of timeliness and compensability. Therefore, in order to establish compensability against Loggers, claimant must show that: (1) his claim is not time-barred; and (2) that he sustained either an injury or occupational disease during his ten hours of truck driving in May 1984. See Wausau Insurance Co. v. Huhnholz, 85 Or App 199, 202 (1986).

Before turning to the merits, we examine whether claimant's claim against Loggers is time-barred. Pursuant to ORS 656.265(4)(a), failure to provide timely notice does not bar a claim if the employer had knowledge of the injury or has not been prejudiced by failure to receive notice. Here, claimant's uncontradicted testimony is as follows:

> "Q. Okay. And what did that do as far as your back condition was concerned?
>
> "A. Well, by noon, I told the superintendent I wasn't going to make it, because I'd taken so many pills I was -- I -- I just wasn't going to make it.
>
> "Q. Okay. And did that lay you up for a period of time?
>
> "A. I told him I was going to go to the doctor the next day. I wouldn't be at work. I told him at noon -- Gene." (Emphasis added).

Under such circumstances, we conclude that the employer knew of the injury, even though it may have had good reason to believe that no claim would be filed. Hayes-Godt v. Scott Wetzel Services, 71 Or App 175, 179 (1984). Accordingly, claimant's claim against Loggers is not time-barred.

Neck Condition

Prior to the August 1983 injury, claimant's prior head and neck complaints largely resolved. In fact, after the October 1980 low back surgery, Dr. Kendrick's medical reports consistently state that claimant was doing "well" outside of occasional low

back pain. Immediately following the August 1983 injury, however, Dr. Kendrick noted both neck and right shoulder pain. This was confirmed by Dr. Sulkosky, who prescribed a cervical collar. Although we do not disturb the Referee's credibility finding, we note that claimant testified to head and right shoulder pain following the August 1983 injury. Accordingly, the preponderance of the medical evidence and lay testimony shows a material contribution between the August 1983 injury and claimant's neck complaints.

Low Back Condition

Following the August 1983 injury, there is no mention in the medical evidence of any low back difficulties until claimant's off-the-job fall in October 1983. As a result of the fall, claimant was briefly hospitalized with a diagnosis of lumbosacral strain and/or lumbar disc disease. Dr. Kendrick opined that the off-the-job fall had "exacerbated an old low back problem." Thereafter, there is no mention of any low back difficulty until after claimant returned to one day of work for Logger's insured in in May 1984. Significantly, however, claimant testified that his low back began hurting before he began working and while he was traveling to Logger's insured. No accident or trauma occurred at Logger's insured.

Although the Referee found claimant's credibility suspect, we do not view the Referee's credibility finding as diminishing the probative weight of claimant's admission concerning the off-the-job onset of his low back pain. That is, the Referee's credibility finding weakens, rather than strengthens, claimant's case.

Dr. Kendrick examined claimant in March 1984 and found no low back problems. Kendrick next saw claimant in May 1984, stating, in part: "the [claimant] spent ten hours driving that truck and had marked pain in the neck and in the low back." There is no acknowledgment by Kendrick, however, that claimant's low back pain began hurting before he started driving the truck.

After considering claimant's testimony and Dr. Kendrick's opinion, we are not persuaded by a preponderance of the evidence that the August 1983 injury was a material contributing cause of claimant's current low back condition; nor are we persuaded that the ten hours of truck driving in May 1984 was either a material contributing cause or the major contributing cause of claimant's current low back condition or its worsening.

Psychological Condition

In September 1985, Dr. Dimitman related "some" of claimant's lack of self-esteem to his "physical disability." Yet, at the time of Dimitman's opinion, much of claimant's physical disability related to his low back condition, which is not a compensable condition against either EBI or Loggers. Second, Dr. Kendrick relates claimant's reactive depression to claimant's "injury." Given the fact that Kendrick related claimant's other conditions to the ten hours of truck driving in May 1984, rather than the August 1983 injury, we interpret Kendrick's use of the word "injury" as referring to events in May 1984. However, inasmuch as we have found that Kendrick had an incomplete and inaccurate history concerning the ten hours of truck driving in May 1984, we find his opinion unpersuasive. Last, Dr. Herz

provides no opinion on the etiology of claimant's psychological condition.

On this record, we are unable to find that either the August 1983 injury or the ten hours of truck driving in May 1984 materially contributed to claimant's psychological condition.

ORDER

The Referee's order is modified in part and affirmed in part. That portion of the Referee's order that upheld EBI Companies' partial denial is modified. EBI's partial denial is set aside to the extent that it denied compensability of claimant's current neck condition. Accordingly, claimant's attorney is awarded a reasonable attorney fee of $900 for his services at hearing concerning this issue. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded a reasonable attorney fee of $600 for his services on Board review concerning the issue of compensability for claimant's condition, to be paid by EBI Companies.

CHARLES M. POOLE, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-08304
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Seifert's order that found he was not a regularly employed worker. Although the self-insured employer has not formally cross-requested review, it argues that: (1) the Referee erred in ordering it to recalculate claimant's temporary total disability benefits based on an a higher hourly rate; (2) in assessing an apparent 10 percent penalty; and (3) in awarding an attorney fee. The issues are temporary total disability and penalties and attorney fees.

The Board affirms the order of the Referee with the following comment.

The Referee concluded his order with the following instructions:

> "that the claim be remanded to the insurer for the payment of compensation as calculated under OAR 436-60-020(4)(c) at the hourly rate of $6.08 along with 10 percent of the increased compensation." (Emphasis added).

The underlined portion of the above quoted passage could be construed as a penalty assessed against the employer. After our de novo review of the lay testimony and documentary evidence, we conclude that the employer did not act unreasonably in calculating or paying claimant's temporary total disability benefits. CRS 656.262(10). Accordingly, a penalty is not appropriate.

ORDER

The Referee's order dated December 17, 1986 is affirmed as supplemented herein.

DENNIS C. REDDON, Claimant
Tamblyn & Bush, Claimant's Attorneys
Stoel, Rives, et al., Defense Attorneys

WCB 86-05001
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Pferdner's order that set aside its denial of claimant's aggravation claim relating to his low back and awarded claimant 20 percent (64 degrees) unscheduled permanent partial disability for his low back. The employer also contends that the Referee erred in excluding two exhibits. The issues are evidence, aggravation and extent of disability.

The Board affirms the Referee on the evidentiary issue. The exhibits were not submitted with a supplemental index which satisfied the requirements of OAR 438-07-005(3)(b). On the merits, however, we reverse. After our de novo review of the evidence, we find that claimant recovered from his industrial injury without permanent impairment and that his worsened low back condition relates to a congenital or developmental defect which was made symptomatic by off-the-job activity. We, therefore, reinstate the employer's aggravation denial and reverse the Referee's award of unscheduled permanent partial disability.

ORDER

The Referee's order dated December 19, 1986 is reversed. The self-insured employer's aggravation denial dated March 5, 1986 is reinstated and affirmed.

R.D. ROBBINS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-12202
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Lipton's order that set aside its denial of claimant's occupational disease claim for an asthmatic condition. Claimant cross-requests review of that portion of the order that determined his condition to be nondisabling. The issues are compensability and jurisdiction.

The Board affirms the order of the Referee with the following supplementation. When a Referee orders a claim accepted, the insurer has the duty to process the claim in accordance with law. These processing obligations include the insurer's initial determination as to whether the claim is considered disabling or nondisabling. See ORS 656.262. Inasmuch as the sole issue before the Referee was compensability, the Referee's comments regarding disability were unnecessary. See Irene Jensen, 39 Van Natta 291 (1987).

Furthermore, we find this case to have been of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated February 11, 1987 is affirmed. The

SAIF Corporation is directed to process the claim in accordance with law. Claimant's attorney is awarded $500 for services on Board review to be paid by the SAIF Corporation.

MARGARETTE I. SCHAFFER-WRIGHT, Claimant
Martin J. McKeown, Claimant's Attorney
Cummins, et al., Defense Attorneys

Own Motion 87-0594M
October 19, 1987
Own Motion Determination

This matter has been referred to the Board for closure pursuant to its own motion authority under ORS 656.278. We conclude that we have jurisdiction.

On January 24, 1980, claimant filed her claim for "bruised and irritated" feet, contending that her condition arose sometime between August 1978 and February 1979. Dr. Arbeene, claimant's treating orthopedist prescribed medication, arch supports and anterior heels. However, claimant was not restricted from her regular work activities. The self-insured employer accepted the claim as nondisabling.

On January 26, 1981, Dr. Arbeene restricted claimant from performing her regular work activities for two weeks. Diagnosing bilateral plantar fascitis, Dr. Arbeene related the condition to claimant's compensable injury. On February 10, 1981, Dr. Arbeene released claimant to her regular work duties.

In April 1981, the employer notified the Compliance Division that it had accepted the claim, which had evolved from nondisabling to disabling. The date of injury was noted as approximately August 1, 1978. The employer further indicated that temporary total disability benefits had been paid between January 27, 1981 and February 9, 1981.

For the next several years, claimant continued to periodically seek medical treatment, but apparently missed no additional time from work as a result of her compensable condition. Eventually, claim closure was requested, resulting in a May 14, 1985 Determination Order. Pursuant to the order, claimant was awarded two weeks of temporary total disability and approximately five months of temporary partial disability. Both awards concerned disability periods occurring in 1981. The Determination Order further stated that the date of injury was August 1, 1978 and that claimant's five-year aggravation rights had begun May 14, 1985.

On June 13, 1985, following reconsideration, the Evaluation Division awarded 5 percent scheduled permanent disability for each foot. The dates for claimant's injury and aggravation rights remained unchanged. This award was appealed and was subsequently increased by a May 1986 Referee's order to 15 percent permanent disability for each foot.

On June 2, 1986, Dr. Arbeene again concluded that claimant was unable to perform her regular work activities. Relating claimant's chronic plantar fascitis condition to her compensable injury, Dr. Arbeene expected that she would be off work for approximately six weeks. On July 14, 1986, Dr. Arbeene released claimant to return to her regular work activities. The employer paid temporary disability benefits for this period.

Thereafter, claimant's symptoms persisted, prompting her referral to Dr. LaFrance for a neurological evaluation. Nerve conduction studies, particularly on the right foot, were

suggestive of a partial nerve injury. Diagnosing probable tarsal tunnel syndrome, Dr. LaFrance recommended decompressive surgery. Dr. LaFrance related claimant's condition to her compensable injury.

In September 1986, Dr. Arbeene sought authorization for surgery. Sometime thereafter, claimant was seen in consultation by Dr. Weilikoff, who also diagnosed chronic plantar fascitis, but felt that it was unlikely that the condition was related to the compensable incident. A hearing request either directly or indirectly concerning this medical services issue is currently pending in WCB Case No. 86-13929. When claimant returned to Dr. Arbeene in January 1987, he was "more pessimistic regarding any possible benefit" from surgery. Consequently, Dr. Arbeene recommended further conservative treatment.

In February 1987, Dr. Hahn, D.P.M., performed an independent medical examination. Dr. Hahn did not believe that claimant had chronic plantar fascitis, but agreed that she was suffering from bilateral tarsal tunnel nerve entrapment. Dr. Hahn could not determine that claimant's current nerve symptoms were directly attributable to her work activities. However, Dr. Hahn conceded that twelve hour shifts on concrete floors would aggravate the problem.

In May 1987, Dr. Arbeene restricted claimant to half days. In addition, she was provided with a prescription for new shoes. Dr. Arbeene continued to attribute claimant's chronic bilateral heel complaints to her compensable injury.

In June 1987, Dr. Rosenbaum neurosurgeon, performed an independent medical examination. Dr. Rosenbaum noted the presence of paresthesia and hyperesthesia which raised the possibility of either a small fiber neuropathy or myelopathy. Although he was unable to attribute claimant's peripheral neuropathic symptoms to her occupation, Dr. Rosenbaum conceded that he could not exclude the coexistence of a plantar fascitis. Consequently, Dr. Rosenbaum deferred to podiatric and orthopedic opinion concerning the existence of plantar fascitis and its contribution to claimant's current symptoms.

On July 22, 1987, the employer issued a partial denial. The employer contended that claimant's bilateral plantar fascitis, peripheral neuropathy, and myelopathy were not related to her 1978 compensable injury. In addition, the employer denied claimant's surgery request.

Coinciding with this partial denial, the employer submitted the claim to the Evaluation Division for closure. The employer asserted that it had paid temporary disability benefits between June 2, 1986 and July 13, 1986. Noting the date of claimant's original injury, the Evaluation Division referred the claim to the Board for closure pursuant to ORS 656.278. We concur with this action.

At the time of claimant's compensable injury, no statute required closure of a claim for a nondisabling injury. ORS 656.268(3), which requires carrier closure of a nondisabling claim, became effective on January 1, 1980. Or Law 1979, ch 839 § 4(3) and 33; Webb v. SAIF, 83 Or App 386 (1987). In addition, the 1978-79 version of ORS 656.262(11) (now ORS 656.262(12)) provided that if within one year after the injury, a worker claimed that a nondisabling injury had become disabling, the

insurer or self-insured employer should immediately report the claim to the director. However, if the claim that a nondisabling injury had become disabling was made more than one year after the date of injury, the claim was to be treated as an aggravation claim pursuant to ORS 656.273. Finally, if the injury was nondisabling and no determination had been made, a claim for aggravation had to be filed within five years after the date of injury. ORS 656.273(4)(b).

Here, claimant's condition resulting from her 1978-79 compensable nondisabling injury worsened in January 1981. Correctly determining that the nondisabling injury had become disabling more than one year from the date of injury, the employer processed the claim as an aggravation. Thereafter, albeit well after claimant's condition had stabilized, the employer submitted the claim to the Evaluation Division for closure.

Since the compensable injury had been nondisabling and no determination had been made, claimant's aggravation rights were statutorily required to have commenced as of the date of injury. ORS 656.273(4)(b). That is, either August 1, 1978, at the earliest, or February 28, 1979, at the latest. Unfortunately, the May 14, 1985 Determination Order inaccurately stated that claimant's aggravation rights began as of the date of the order. Although this information was clearly misleading, we have previously held that a statement on an administrative form cannot modify the express language of controlling statutes. See Bert E. Miltenberger, 39 Van Natta 68, 70 (1987).

Inasmuch as claimant's five-year aggravation rights had terminated, at the latest, by February 28, 1984, the employer's July 1986 actions represent a voluntary reopening of the claim. Consequently, upon submission of the claim for closure, jurisdiction to consider the request lies with the Board pursuant to ORS 656.278.

Turning to the merits of the claim, we are persuaded that claimant's condition temporarily worsened and stabilized between June 2, 1986 and July 13, 1986. Accordingly, claimant is awarded temporary total disability benefits from June 2, 1986 through July 13, 1986. The record fails to establish claimant's entitlement to an additional award of scheduled permanent disability.

In reaching these decisions, we render no opinion concerning the issues currently pending in WCB Case No. 86-13929 or the compensability of the conditions and services denied by the employer in July 1987. Because claimant has a lifetime right to payment for medical treatment for conditions related to her compensable injury, we lack jurisdiction under our own motion authority to consider these issues. ORS 656.245(1); Loretta Sanders, 38 Van Natta 175 (1986); Dwayne G. Carey, 36 Van Natta 265 (1984); William A. Newell, 35 Van Natta 629 (1983). However, upon resolution of these matters, the parties are requested to submit their respective positions concerning whether further own motion relief will be necessary.

IT IS SO ORDERED.

JAY B. STRANDQUIST, Claimant
Robert E. Brasch, Claimant's Attorney
Foss, et al., Defense Attorneys

WCB 86-02856
October 19, 1987
Order on Reconsideration

Liberty Northwest Insurance Corporation requested reconsideration of our Order on Review dated August 31, 1987. We abated our order to allow time for claimant to respond and for us to adequately consider the request. Claimant submitted a two-page argument in favor of reinstating our previous order.

The Referee's order assigned responsibility for claimant's low back condition to an employer who was not a party to the proceeding. We reversed under the rule of Runft v. SAIF, 303 Or 493 (1987) and assigned responsibility to Liberty Northwest. Liberty Northwest now argues that the case should be remanded to the Referee so that it can join the employer which was absent from the prior proceeding. In the alternative, Liberty Northwest argues that claimant failed to prove a compensable worsening of the original low back injury.

The request for remand is denied. Liberty Northwest had an opportunity to join the other employer at the prior hearing. It chose not to do so. We conclude that it has waived joinder of the other employer. Regarding the aggravation issue, we find that claimant's original low back injury remains a material contributing cause of the worsened condition. Claimant, therefore, established a compensable aggravation under ORS 656.273. See Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1982); cf. International Paper Co. v. Comstock, 73 Or App 342, 343, rev den 299 Or 583 (1985).

As supplemented herein, we adhere to and republish our prior order, effective this date. Claimant's attorney is awarded an attorney fee of $200 for services on reconsideration, to be paid by Liberty Northwest. See Daniel J. Sabol, 38 Van Natta 154 (1986).

IT IS SO ORDERED.

VERNON E. SUMMERS, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 86-07710
October 19, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Foster's order that increased claimant's unscheduled permanent disability award from 15 percent (48 degrees), as awarded by a Determination Order, to 40 percent (128 degrees). The issue is extent of permanent disability.

Claimant, a tree faller, was injured in August 1985 when he was struck by a tree in the left shoulder area. He was diagnosed as having a fractured shoulder blade and a possible brachial plexus contusion. His complaints included severe neck pain and pain and numbness in his left arm extending to his fingers.

His treating physician was Dr. Straub, an orthopedic surgeon, who treated claimant conservatively with heat, massage and home traction. Dr. Straub released claimant to his regular work in November 1985. He returned to work for two weeks, but then was off work again due to his complaints.

Claimant again returned to work in December for two weeks, then was laid off. He did not return to work until July 1986. During this six-month period, he was seen by Dr. Straub several times and also by Dr. Jones, a neurologist. In March 1986, Dr. Jones reported that claimant's symptoms were in complete remission with the exception of some residual soreness in his neck. He also reported that claimant had no sensory, motor or reflex abnormalities, and that claimant was able to return to work without limitation.

Dr. Straub opined that claimant was medically stationary in April 1986 and recommended claim closure. He concluded that claimant had a mild impairment with some loss of motion of the shoulder and decreased grip strength and very mild atrophy on the left side. He also noted mild mobility restriction of certain portions of the cervical spine.

Claimant underwent vocational rehabilitation. The efforts focused on returning him to regular work as a timber faller. The medical reports of Drs. Straub and Jones, including a functional capacity report, indicated that he would be able to do so. In July 1986, claimant returned to work as a timber faller. He worked until mid-October, at which time he was again laid off.

A June 1986 Determination Order awarded claimant 15 percent unscheduled permanent disability and 10 percent scheduled disability for loss of the left arm. Claimant requested a hearing.

Claimant was 47 years old at the time of the hearing. He has a tenth grade education. He has been employed as a timber faller for seventeen years. His work outside the woods includes: scrap yard worker, chute man at a flour mill, sheet metal installer, and assembly worker at a car plant. He has some skills as a carpenter and, at one time, operated his own shake mill.

Claimant testified to continuing symptoms upon his return to work in July 1986. Specifically, he stated that he feels like he might pass out whenever he looks upward for any length of time, he needs help carrying his equipment and driving wedges into trees, and his arms go numb when used overhead.

Noting that claimant's only work experience involved heavy physical labor, the Referee found that claimant's earning capacity had been "somewhat diminished" as a result of his injury. Considering claimant's education, background and transferable skills, the Referee increased claimant's disability award from 15 percent to 40 percent.

Although both physicians felt claimant could return to work as a timber faller, they also anticipated that he might have continuing problems. One of Dr. Straub's chart notes indicates that he discussed other employment opportunities with claimant. Dr. Jones indicated that continuing problems might cause claimant to miss some work. A vocational report confirms that claimant was having some problems on the job and that he was requiring help from other employees in order to perform his duties.

We, therefore, agree that claimant's injury and subsequent physical limitations have caused a permanent loss of earning capacity. ORS 656.214(5). However, we consider the Referee's award to be excessive.

In rating the extent of unscheduled permanent disability for claimant's neck and shoulder condition, we consider his physical

impairment as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Here, Dr. Straub rated claimant's physical impairment to be in the mild range. After reviewing the record, we agree. Following our de novo review, and considering the relevant social and vocational factors, we conclude that a 25 percent unscheduled disability award adequately compensates claimant for his compensable neck and shoulder injury.

ORDER

The Referee's order dated February 6, 1987 is modified. In lieu of the Referee's award, and in addition to the Determination Order's award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for the neck and shoulder, giving him a total award to date of 25 percent (80 degrees). Claimant's attorney fee shall be adjusted accordingly.

KATHLEEN R. WARE, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-08460
October 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of that portion of Referee Daron's order that declined to assess a penalty against the SAIF Corporation for an alleged unreasonable termination of his temporary total disability benefits. Although SAIF has not formally cross-requested review, it argues that the Referee erred in ordering it to reinstate claimant's temporary total disability benefits. The issues are penalties and temporary total disability.

We affirm the Referee's order insofar as it: (1) reinstated claimant's temporary total disability benefits; and (2) declined to assess a penalty against SAIF for an alleged unreasonable termination of claimant's benefits.

In reviewing whether SAIF acted unreasonably, we note that the Referee's initial order awarded an insurer paid attorney fee pursuant to ORS 656.382(1). After reconsideration, however, the Referee found that SAIF had not acted unreasonably in terminating claimant's temporary total disability benefits. We agree. Therefore, on de novo review, we find that the Referee's award of an insurer paid attorney fee was incorrect.

Accordingly, claimant's attorney is awarded a reasonable attorney fee payable out of, not in addition to, claimant's increased compensation.

ORDER

The Referee's order dated August 29, 1986, as republished November 21, 1986, is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, claimant's attorney is awarded a reasonable attorney fee equal to 25 percent of claimant's increased compensation not to exceed $750, payable out of and not in addition to claimant's compensation. All remaining portions of the Referee's order are affirmed.

JANICE A. IGO, Claimant
Charles D. Maier, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 87-03544
October 29, 1987
Order Denying Motion to Suspend Enforcement of Referee's Order

The insurer has moved the Board for an order suspending enforcement of a Referee's order. Specifically, the insurer objects to paying a "patently erroneous" award of 35 percent unscheduled permanent disability, pending Board review of the Referee's order.

The insurer's request is contrary to law. ORS 656.313(1) expressly states that the filing of an insurer's request for review shall not stay payment of compensation to a claimant. See Harold D. Tallent, 39 Van Natta 345 (1987).

Accordingly, the motion to suspend enforcement of the Referee's order is denied.

IT IS SO ORDERED.

SHELLI S. JORDAN, Claimant
Merrill Schneider, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-10417
October 29, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Jordan v. SAIF, 86 Or App 29 (1987). The court concluded that claimant's present medical treatment for her right wrist condition is compensable. Consequently, the court reversed the Board's order which had upheld the SAIF Corporation's denial of claimant's medical services claim for her current right wrist condition.

Pursuant to the court's mandate, SAIF's September 5, 1984 denial is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

THOMAS L. RUNFT, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Legal (Portland West), Defense Attorney

WCB 83-03962
October 29, 1987
Order on Remand

This matter is before the Board on remand from the Supreme Court. Runft v. SAIF, 303 Or 493 (1987). We have been instructed to enter an order holding the SAIF Corporation responsible for payment of any compensation to which claimant may be entitled.

Accordingly, pursuant to the Supreme Court's mandate, SAIF's March 21, 1983 denial of claimant's occupational disease claim is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

GLORIA A. BEMBRY, Claimant
Peter Hansen, Claimant's Attorney
William Replogle, Defense Attorney

WCB TP-87003
October 30, 1987
Third Party Interim Order

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Claimant and the third party have agreed to settle claimant's cause of action stemming from a November 1983 automobile accident for $7,500. This accident occurred while claimant's September 1981 injury claim was in "open status." The claim was finally closed in December 1984, pursuant to a Determination Order. The paying agency's medical and indemnity expenses since the November 1983 accident exceed $30,000. Asserting that its statutory share of the settlement offer is "ridiculously insufficient to begin to satisfy its lien," the paying agency refuses to approve the current offer.

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). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement amount appears to be grossly unreasonable. Steven B. Lubitz, 39 Van Natta 809 (September 24, 1987); Virginia Merrill, 35 Van Natta 251 (1983); Rose Hestkind, 35 Van Natta 250 (1983).

However, it has come to the Board's attention that a request for Board review is currently pending in WCB Case No. 84-10824. Among the issues to be addressed in the pending request are the extent of claimant's temporary and permanent disability resulting from her compensable injury.

Inasmuch as there has not been a final order determining the extent of claimant's disability arising out of her compensable injury, we deem it appropriate to hold this third party proceeding in abeyance. John J. O'Halloran, 34 Van Natta 1504 (1982). Upon final resolution of the disability issues in WCB Case No. 84-10824, the parties shall so advise the Board. At that time, the Board will resume its review of this third party dispute.

BILLY JACK KUYKENDALL, Claimant
Ray Williams, Attorney
Ann Kelley, Ass't. Attorney General

WCB CV-87006
October 5, 1987
Crime Victim Order

Applicant has requested review by the Workers' Compensation Board of the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated March 26, 1987. By its order, the Department accepted applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. However, finding that applicant was the "initial aggressor" in the altercation that resulted in his injuries, the Department awarded compensation equal to 50 percent of his medical, hospital, and rehabilitation expenses, within statutory maximums.

In lieu of a fact finding hearing, the parties have agreed to submit the case for review based on the documentary record provided by the Department of Justice and the parties' written arguments. See OAR 438-82-030(2). The written arguments have been received and fully considered.

The standard for our review under the Act is de novo, based on the entire record. ORS 656.147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings.

Applicant timely filed a claim for compensation, asserting that he was the innocent victim of the unprovoked crime of attempted murder on August 26, 1986. In conjunction with his claim, applicant submitted a "Crime Victim's Statement." In the October 21, 1986 statement, applicant contends that he was leaving the restroom of a Milton-Freewater bar, when James Struthers confronted him and insisted that they "step out the back door and 'settle this once and for all.'" As they were leaving the bar, applicant saw Struthers reach into his pocket and pull out something shiny. Thinking Struthers had a knife, applicant struck him in the jaw. Thereafter, Struthers took several steps back into the bar and shot applicant in the chest with a "38 snub nose" revolver.

Applicant's September 3, 1986 statement to the police parallels his "Crime Victim's Statement." However, in the police report, applicant notes that he only saw Struthers put his left hand into his pocket. There is no mention of a shiny object. Furthermore, applicant stated that he was shot after returning to the bar. Still another account of the incident was contained in an undated "Oregon Corrections Division Presentence Investigation" report. In this account, applicant struck Struthers after seeing Struthers put his hand in his right front pocket. Again, applicant was shot after going back into the bar.

Several witnesses to the altercation provided statements to the police. Trudy Clark, who was standing outside talking to David Hall, saw applicant and Struthers exit the bar. Clark stated that applicant threw a punch at Struthers. Then after applicant and Struthers returned to the bar, Clark heard a shot, and saw applicant come out the door.

Before the shooting, Hall heard applicant accusing Struthers of bothering him. According to Hall, Struthers dared applicant to fight, then attempted to hit him with a left jab. As Struthers and applicant returned to the bar, Hall saw Struthers reach into his right front pocket. The shot soon followed.

Kenneth Moss was leaving the bar when he saw applicant and Struthers standing near the back door. According to Moss, applicant struck Struthers. Then, as Struthers backed into the bar, he reached into his right front pocket as if he was "going for a knife." The shot then rang out.

Gary Cox accompanied Moss to the bar. Cox, who was acquainted with Struthers, talked to him prior to the incident. Cox stated that he "realized then that "[Struthers] was screwed up by drinking and partly by drugs, but I'm no doctor."

Struthers advised the police that he had asked applicant to go outside. When he saw two people standing outside, Struthers suggested that they "go up the street aways." It was at this point that applicant struck Struthers. Returning to the bar, Struthers decided to shoot applicant. He then reached into his right front pocket, drew his pistol, and fired.

Struthers' friend, Gerald Stoddard, accompanied

Struthers to the bar. Stoddard did not hear an argument, but he saw the two men heading for the back door. When Stoddard arrived at the door, he noticed that Struthers mouth was bleeding. Not wanting to get involved, Stoddard returned to his table. About that time, he heard a shot.

On December 22, 1986, the Department issued its Findings of Fact, Conclusions and Order, accepting applicant's claim. However, finding that applicant was the "initial aggressor," the Department awarded only 50 percent of applicant's medical, hospital, and rehabilitation services, up to a statutory maximum. The Department was persuaded that Struthers reached into his pocket and shot applicant, only after being struck by applicant.

Applicant requested reconsideration, contending that he struck Struthers because he was acting in self-defense. The Department issued an Order on Reconsideration on March 26, 1987, adhering to its prior order. The Department concluded that applicant had provoked Struthers by striking him. However, since Struthers actions were excessive, the Department continued to find that applicant was entitled to 50 percent of the maximum compensation allowable by statute. Thereafter, applicant timely requested review by the Workers' Compensation Board.

CONCLUSIONS

ORS 147.015 provides that an applicant is entitled to compensation under the Act if, among other requirements:

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

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

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

On de novo review of this record, we are not persuaded that applicant's actions were sufficiently substantial so as to prevent him from receiving compensation. See ORS 147.015(5); OAR 137-76-010(7), (8). However, the preponderance of the record establishes that applicant's conduct either provoked or, at least, contributed to his injury. See ORS 147.125(3). Consequently, we conclude that the Department was justified in reducing applicant's award of compensation.

The evidence suggests that Struthers initiated the altercation by confronting applicant and proposing that they leave the bar to "settle this once and for all." Yet, applicant was under no obligation, implied or otherwise, to accede to Struthers' demands. Furthermore, considering Struthers' apparent state of

intoxication, a restrained and nonviolent exchange of views outside of the bar was not reasonably foreseeable.

Moreover, once they left the bar, applicant exacerbated the situation by striking Struthers. Applicant contends that the punch was justified, since he saw Struthers reaching into his pants for a shiny object. However, the remaining portions of this record do not support this contention. Rather, the preponderance of the evidence indicates that Struthers reached for his pocket after applicant struck him.

The criminal actions of Struthers were clearly excessive and designed to end applicant's life. Fortunately, the attempt was unsuccessful. Yet, the preponderance of the persuasive evidence establishes that applicant's conduct contributed to this violent episode. Therefore, the Department was justified in reducing applicant's award of compensation resulting from this incident. See ORS 147.125(3). Finally, considering the circumstances described herein, we further conclude that a 50 percent reduction was appropriate. Accordingly, the Department's Order on Reconsideration shall be affirmed.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated March 26, 1987 is affirmed.

DOUGLAS D. DUTTON, Claimant
Helm, et al., Claimant's Attorneys
Williams, et al., Defense Attorneys

Own Motion 87-0267M
November 2, 1987
Second Own Motion Order on Reconsideration

The Board issued an Own Motion Order on August 26, 1987 whereby claimant's claim was reopened with benefits to commence March 16, 1987. On September 3, 1987 the insurer asked the Board to reconsider its order, contending claimant was entitled to benefits only from the date of surgery which was to take place in late August or early September 1987. By order dated September 21, 1987 the Board affirmed its earlier order.

Claimant asks the Board for penalties and attorney fees for the insurer's failure to pay benefits as ordered by the Board in a timely manner. The insurer has indicated that all benefits, which included the claimant's attorney's fee, were paid directly to claimant on October 2, 1987, shortly after receipt of the Board's second order. Claimant contends benefits were due on the 14th day after the first order and indicates that no attorney fee has been paid to his attorney.

Although payment of claimant's benefits did not take place on the 14th day after issuance of the first Board order, we find that the insurer was not unreasonable in its delay of payment. The insurer promptly requested reconsideration of the Board's order and, in good faith, expected either a second order or an abatement of the first order before the 14th day. When the Board issued its order on September 21, the insurer then paid the benefits due.

Although many insurer's issue a check to the injured worker and a second check to the attorney for payment of fees,

there is no requirement in the law that payment must be handled in this manner. We find no reason to penalize the insurer for its handling of claimant's attorney's fee. The insurer has paid claimant's attorney fees directly to claimant and claimant's attorney must look to his client for payment.

After thorough consideration of this matter, we conclude claimant's request for penalties and attorney fees must be denied.

IT IS SO ORDERED.

RENE VAN WOESIK, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-10819
November 2, 1987
Order on Reconsideration

Claimant requests reconsideration of the Board's October 12, 1987 Order on Review that affirmed the Referee's order which declined to modify the Director's finding that claimant was not entitled to additional vocational services. Claimant reiterates his prior contention that the Referee's order should be reversed.

The request for reconsideration is granted and our prior order withdrawn. Following our further review, we remain unpersuaded that the decision of the Director: (1) violated a statute or rule; (2) was made upon lawful procedure; or (3) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. See ORS 656.283(2).

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

IT IS SO ORDERED.

TIMOTHY W. ELDER, Claimant
Malagon & Moore, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 85-05329
November 4, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated October 12, 1987 which affirmed the Referee's order finding that claimant's carpal tunnel syndrome claim had not been prematurely closed.

The request is granted and our prior order withdrawn. In finding that claimant's claim had not been prematurely closed, the Referee stated that the propriety of claim closure is determined by considering the evidence available at the time the Determination Order was issued. Thus, based upon the evidence available at the time of closure, the Referee concluded that claimant was properly determined to be medically stationary on the date stated by the Determination Order.

Subsequent to the issuance of the Referee's order the Court of Appeals rendered its decision in Schuening v. J.R. Simplot & Company, 84 Or App 622 (1987). The court stated that the Referee and Board may consider medical evidence concerning a claimant's condition on the date of closure that was not available to the Evaluation Division at the time of closure.

Following our further review of the record, which included all medical evidence regarding claimant's condition on

the date of claim closure, we continue to find that the claim was not prematurely closed. Furthermore, we continue to find that claimant is not entitled to additional temporary total disability.

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

IT IS SO ORDERED.

BRUCE M. PAPROCK, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 86-01782
November 4, 1987
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of those portions of Referee Garaventa's order that: (1) set aside its denial of claimant's industrial injury claim for right carpal tunnel syndrome; and (2) assessed an attorney fee against the insurer on the ground that the denial was unreasonable. The issues are compensability and attorney fees.

The Board affirms the order of the Referee on the compensability issue. On the issue of attorney fees, however, we reverse. In finding the insurer's denial unreasonable, the Referee relied upon a medical report which was not issued until two months after the date of the denial. The reasonableness of an insurer's denial must be gauged from the information available to the insurer at the time of the denial. Price v. SAIF, 73 Or App 123, 126 n.3 (1985); Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355, 358 (1983).

At the time of its denial, the insurer was aware that prior to the industrial injury claimant had sustained a serious nonindustrial injury to his right arm and also had received a report from Dr. Horniman, a consulting general practitioner, which related neurological symptoms in claimant's right hand to this injury. These facts provided a reasonable basis for the insurer's denial of claimant's right carpal tunnel syndrome.

ORDER

The Referee's order dated January 7, 1987 is affirmed in part and reversed in part. That portion of the order that awarded claimant's attorney an attorney fee of $350 in connection with the compensability denial on the ground that the denial was unreasonable, is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services on Board review in connection with the compensability issue, to be paid by the insurer.

PATRICK G. BRYANT, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-13163
November 5, 1987
Order Denying Motion for Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated October 7, 1987.

The motion for reconsideration lacks a concise statement of the reason for request. See OAR 438-11-030(2). Consequently, the motion is denied.

The parties' rights of appeal shall continue to run from the date of the Board's Order on Review.

IT IS SO ORDERED.

DANNY H. COLLINS, Claimant
Gatti, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-00760
November 5, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987). The court concluded that claimant had established that his employment exposure to a chemical spray was the major contributing cause of his respiratory symptoms and need for medical services. Consequently, the court reversed the Board's order which had upheld the SAIF Corporation's denial of claimant's claim.

Pursuant to the court's instructions, SAIF's January 14, 1985 denial is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

The Beneficiaries of
JOHN K. EDER (Deceased),
JANE EDER, Claimant
Pozzi, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 86-12509
November 5, 1987
Order on Reconsideration

The insurer requests reconsideration of that portion of the Board's October 19, 1987 Order on Review that assessed penalties and attorney fees for the insurer's failure to pay medical benefits pursuant to a prior Referee's order pending review of that order. The insurer contends that its conduct was not unreasonable and that a $500 attorney fee is excessive.

The request for reconsideration is granted and our prior order withdrawn. Upon further review, we continue to find that the insurer's failure to comply with a prior Referee's order and process claimant's medical services claim pursuant to the law in effect at the time of the 1976 compensable injury was unreasonable. Furthermore, we consider the penalty-associated attorney fee award to be reasonable.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

MICHELLE L. MAPLETHORPE, Claimant
Peter O. Hansen, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-13877
November 5, 1987
Order Denying Motion for Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated October 7, 1987.

The motion for reconsideration lacks a concise statement of the reason for request. See OAR 438-11-030(2). Consequently, the motion is denied.

The parties' rights of appeal shall continue to run from the date of the Board's Order on Review.

IT IS SO ORDERED.

RICHARD E. POLIER, Claimant
Peter O. Hansen, Claimant's Attorney
Williams, et al., Defense Attorneys

WCB 85-06710 & 85-08743
November 5, 1987
Order Denying Motion for Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated October 7, 1987.

The motion for reconsideration lacks a concise statement of the reason for request. See OAR 438-11-030(2). Consequently, the motion is denied.

The parties' rights of appeal shall continue to run from the date of the Board's Order on Review.

IT IS SO ORDERED.

ODUS L. STILWELL, Claimant
Peter O. Hansen, Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys

WCB 86-09081
November 5, 1987
Order Denying Motion for Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated October 8, 1987.

The motion for reconsideration lacks a concise statement of the reason for request. See OAR 438-11-030(2). Consequently, the motion is denied.

The parties' rights of appeal shall continue to run from the date of the Board's Order on Review.

IT IS SO ORDERED.

DIANE L. CARRANZA, Claimant
Luvaas, Cobb, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-05828 & 86-05829
November 6, 1987
Order on Review

Reviewed by Board Members Johnson and Crider.

EBI Companies (EBI) requests review of that portion of Referee Seymour's order that set aside its denial of claimant's occupational disease claim for a left arm condition and upheld St. Paul Mercury Insurance's (St. Paul) denial of her occupational disease claim for the same condition. The issue is responsibility.

The Board affirms the order of the Referee with the following comment.

Claimant began working for the employer in December 1983. Her job included various clerical duties such as typing and bookkeeping. Prior to the spring of 1985, she had no problems with her hands or arms. In March 1985, she began to experience difficulty with her left arm. Accordingly, she consulted Dr. Pyfer, a surgeon, who eventually diagnosed thoracic outlet syndrome.

On April 1, 1985, the employer changed insurers from St. Paul to EBI.

Claimant continued working after seeing Dr. Pyfer, despite worsening pain. Thereafter, she filed occupational disease claims against both insurers. She never took time off from work as a result of either claim. Both insurers ultimately conceded compensability and denied solely on the basis of responsibility. Accordingly, an amended ORS 656.307 order issued in July 1986 designating St. Paul as the paying agent.

Dr. Karasek, claimant's treating neurologist, responded to several inquiries from both parties and ultimately concluded that claimant's pathology increased after April 1, 1985. Likewise, Dr. Jewel, a surgeon, opined that claimant's employment activities after April 1, 1985 worsened her underlying condition.

Finding that "claimant's current condition was materially worsened by work activities after April 1, 1985," the Referee concluded that EBI, as the later insurer, was responsible for claimant's current condition. We affirm the Referee with the following comment.

This case involves two unaccepted occupational disease claims and each insurer has conceded that claimant's condition is work related. Accordingly, the last injurious exposure rule applies to shift responsibility to the later employer/insurer if its employment conditions contribute to the cause of, aggravate, or exacerbate a claimant's underlying disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). Here, the weight of the medical evidence indicates that claimant's left arm condition worsened as a result of her employment activities after April 1, 1985. Accordingly, we find that EBI is responsible for claimant's current condition.

EBI argues that it is not responsible for claimant's current left arm condition because she first sought medical treatment in March 1985, while St. Paul was the insurer. We are not persuaded by EBI's argument.

True, when a claimant is not disabled from work, as here, the "triggering event" for the assignment of responsibility is the date in which he/she first seeks medical treatment. SAIF v. Carey, 63 Or App 68, 70 (1983); Progress Quarries v. Vaandering, 80 Or App 160, 163 (1986). However, the inquiry does not end there. Rather, the "triggering event" only establishes the beginning date for a determination of the "last potentially causal [insurer]." Carey, 63 Or App at 70 (Emphasis added). Here, claimant first sought treatment for his left arm condition while St. Paul was on the risk. However, as previously noted, the record establishes that claimant's subsequent work activities while EBI was on the risk worsened his left arm condition. Accordingly, we have found that EBI was the "last potentially causal [insurer]."

ORDER

The Referee's order dated January 21, 1987 is affirmed as supplemented herein.

JANET E. LONG, Claimant
Royce, Swanson & Thomas, Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys

WCB 86-6429
November 6, 1987
Second Order on Reconsideration

The insurer has requested reconsideration of that portion of the Board's October 19, 1987 Order on Reconsideration which adhered to its September 19, 1987 Order on Review that found claimant's medical service claim for a jacuzzi and recliner chair was compensable. The insurer contends that the medical reports do not satisfy the requirements of OAR 436-10-040(7) and, therefore, the claim is not compensable.

The request for reconsideration is granted and our prior orders are withdrawn. Upon further review, we continue to find claimant's medical service claim compensable for the reasons stated in our September 29, 1987 order.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our former orders, effective this date.

IT IS SO ORDERED.

ABRAHAM HEAMISH, Claimant
Schwabe, et al., Defense Attorneys

WCB 86-17367
November 9, 1987
Order Dismissing Request for Review and Remanding

Reviewed by Board Members Ferris and Johnson.

Claimant has requested Board review of Referee Daughtry's October 1, 1987 Interim Order which resolved several evidentiary motions and directed that the case be set for hearing. We have reviewed the request to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither finally denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's "interim" order neither finally disposed of, nor allowed, the claim. Rather, the order resolved several evidentiary matters in preparation for a forthcoming hearing. Since further action before the Hearings Division was required as a result of the Referee's order, we conclude that it was not a final appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issues raised by the request for review.

Accordingly, the request for Board review is dismissed. This case is remanded to the Hearings Division for further proceedings consistent with the Referee's Interim Order.

IT IS SO ORDERED.

MARCIA L. DURAN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-06270
November 10, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Leahy's order that affirmed a Determination Order that awarded 5 percent (7.5 degrees) scheduled permanent partial disability for loss of use or function of the right forearm (wrist) and no permanent disability for the left forearm (wrist). On review, the issue is extent of permanent disability. We affirm the Referee's order with the following comment.

Claimant was 34 years old at the time of hearing. Shortly after beginning work as a production worker, claimant filed a claim for bilateral carpal tunnel syndrome. The claim was accepted. Thereafter, carpal tunnel release surgery was performed on both wrists.

In February 1986 Dr. Franks, claimant's treating physician, noted that claimant had no significant remaining numbness or lingering dysesthesia of the radial side of the right finger. Although claimant had a full range of motion of both wrists she experienced mild residual tenderness at the incision site of the right carpal tunnel release. Dr. Franks opined that the pain should subside.

An April 8, 1986 Determination Order awarded 5 percent scheduled permanent disability for loss of use of the right forearm (wrist).

Claimant testified that she was currently working as a sales ticket auditor and operated a 10 key punch. On a bad day her right hand cramps and she experiences severe shooting pain through her elbow up to her shoulder. She estimated that she has lost approximately one-fourth of her strength in her right arm. Claimant further indicated that her arm fatigued after a day's work. In addition, she experienced similar symptoms and limitations in her left hand. Claimant estimated that she could lift 20 pounds with her right arm, and that extending her arm caused aching.

The Referee concluded that claimant was unreliable because he gave confusing dates of employment he lost some faith in what otherwise appeared to be her straightforward testimony. Consequently, he relied upon the medical records and found that claimant was not entitled to additional awards of permanent disability.

The criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury or disease. ORS 656.214(2). OAR 436-30-190 and 436-30-220 set forth guidelines to assist in the determination of the extent of permanent disability caused by a forearm (wrist) injury. Although these rules are not binding, because they are based on accepted medical principles, they are highly persuasive. Harwell v. Argonaut Ins. Co., 296 Or 505 (1984). In addition to these guidelines, however, disabling pain resulting from the compensable condition is to be considered. Harwell, 296 Or at 510.

Although the Referee considered claimant's credibility to be diminished, this conclusion was based upon claimant's apparent confusion concerning her dates of employment and not upon her demeanor. Generally, in exercising de novo review, we defer to the Referee's determination of credibility due to the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). However, when credibility is based upon the substance of the witnesses' testimony a reviewing body is as capable of evaluating the witness as is the Referee. Coastal Frame Supply v. Hullberg, 84 Or App 282 (1987). Based upon our review of the record, we do not consider claimant's credibility diminished.

Following our de novo review of the medical and lay evidence concerning claimant's objective and subjective complaints, we conclude that a 5 percent scheduled permanent disability award adequately compensates claimant for the loss of use or function of her right forearm (wrist). ORS 656.214(2)(b). Furthermore, we are not persuaded that claimant is entitled to a scheduled permanent disability award for the loss of use or function of her left forearm (wrist). Accordingly, we affirm the order of the Referee.

ORDER

The Referee's order dated February 11, 1987 is affirmed.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-12353
November 10, 1987
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of that portion of Referee Neal's order that granted claimant an award of permanent total disability, whereas claimant had previously received 60 percent (192 degrees) unscheduled permanent disability for a left hip injury and 25 percent (37.5 degrees) scheduled permanent disability for a left leg injury. The issues are whether claimant is permanently and totally disabled and whether SAIF is entitled to offset permanent disability payments paid claimant pursuant to a prior Determination Order.

The Board affirms the order of the Referee with the following modification concerning the offset issue. We agree with SAIF that it is entitled to an offset of permanent partial disability paid between the effective date of the permanent total disability award and the date of the Referee's order. See Pacific Motor trucking Co. v. Yeager, 64 Or App 28, 31-32 (1983); Donald V. Wilkinson, 37 Van Natta 937 (1985); Guy M. Shorb, 39 Van Natta 1038 (October 19, 1987).

We find the extent of disability issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee for services on Board review is therefore awarded.

ORDER

The Referee's order dated January 23, 1987 is affirmed and modified to authorize the SAIF Corporation to offset against permanent total disability benefits due any permanent partial disability benefits paid subsequent to September 18, 1985. Claimant's attorney is awarded $500 for services on Board review, to be paid by SAIF.

ROBERT E. KEYS, Claimant
Charles D. Maier, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-02336
November 10, 1987
Order Denying Motion to Stay

The insurer has moved the Board for an order suspending enforcement of a Referee's order awarding claimant 10 percent (32 degrees) unscheduled permanent disability. Specifically, the insurer requests this stay until such time as the insurer's post-hearing "backup" denial can be litigated. The insurer contends that the stay might allow it to recover the permanent disability benefits paid on what it asserts "may likely prove to be a fraudulent claim that will be finally denied."

In support of its motion, the insurer cites Hannum v. EBI Companies, 83 Or App 346 (1987). In Hannum, after learning of a previously undisclosed off-the-job injury at a hearing concerning the extent of claimant's permanent disability, the insurer issued a "backup" denial of an aggravation claim "on the basis of fraud and misrepresentation." Before the hearing on the "backup" denial, the Board, with one member dissenting, stayed both the appeal and enforcement of the Referee's order awarding permanent disability. Patrick H. Hannum, 36 Van Natta 1680 (1984). The "backup" denial was eventually upheld by the Board. Thereafter, the claimant sought review, but only of the Board's order upholding the denial. Hannum v. EBI Companies, supra., page 348. In affirming the Board's order, the court disagreed with claimant's contention that the award of compensation in the aggravation hearing was res judicata and foreclosed an adjudication of compensability.

The Hannum court further stated that it "expressed no opinion as to the propriety of the Board's opinion and order suspending payments" pending review of the Referee's order concerning the extent of claimant's permanent disability. Hannum v. EBI Companies, supra., page 349. Thus, although the court's decision provides authority for the issuance of the insurer's post-hearing "backup" denial, it does not provide authority for the insurer's request to suspend enforcement of the Referee's order. Moreover, we find the Board's "suspension of payments" order in Hannum to be contrary to law. ORS 656.313(1) expressly states that the filing of an insurer's request for review shall not stay payment of compensation to a claimant. See also, Harold D. Tallent, 39 Van Natta 345 (1987). We consider the statute clear and unambiguous. Consequently, the Board's previous holding in Hannum is disavowed.

Inasmuch as the insurer asks that the payment of compensation to claimant be stayed pending further litigation, we conclude that the motion must be denied. See ORS 656.313(1).

Finally, the insurer has also asked for a 14 day extension within which to file its appellant's brief. The extension request is granted. Therefore, the insurer's appellant's brief shall be due 14 days from the date of this order. Claimant's respondent's brief shall be due 21 days from the date of mailing of the appellant's brief. The insurer's reply brief, if any, shall be due 14 days from the date of mailing of the respondent's brief. Thereafter, this matter shall be docketed for review.

IT IS SO ORDERED.

LAVERNE L. MANSELLE, Claimant
Jolles, Sokol, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 84-03105
November 10, 1987
Order on Reconsideration

The insurer has requested reconsideration of the Board's October 13, 1987 Order on Review that: (1) upheld its denial of claimant's aggravation claim relating to his low back; (2) decreased claimant's total award of unscheduled permanent partial disability for his low back from 55 percent (176 degrees) to 35 percent (112 degrees); and (3) reversed a Referee's finding that claimant was entitled to temporary disability compensation during pain center treatment and a work hardening program.

Specifically, the insurer asks for: (1) prior authorization to offset temporary disability benefits paid, pending Board review of the Referee's order, for the period coinciding with claimant's participation in a pain center treatment and work hardening program; and (2) reimbursement from claimant's attorney for overpaid attorney fees which were paid out of claimant's permanent disability award pending review of the Referee's order.

The insurer's requests are contrary to law. ORS 656.313(2) expressly provides that should the Board subsequently order that compensation paid to claimant pending Board review should not have been allowed or should have been awarded in a lesser amount than awarded, claimant shall not be obligated to repay any such compensation. See Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581, rev den 297 Or 340 (1984). In addition, attorney fees awarded out of claimant's compensation are payable pending review. ORS 656.313(1); Candy J. Hess, 37 Van Natta 12 (1985). Moreover, once paid, these fees are not recoverable. ORS 656.313(2); SAIF v. Gatti, 72 Or App 106 (1985).

Accordingly, the request for reconsideration is granted and the Board's prior order withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes its former order, effective this date.

IT IS SO ORDERED.

MERLE F. PARKS, Claimant
Steven C. Yates, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-03139
November 10, 1987
Order on Review (Remanding)

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Quillinan's order dismissing his hearing request for a failure to appear at hearing. The issue is whether there was good cause for claimant's failure to appear.

On March 3, 1986, claimant filed a request for hearing alleging failure to pay medical bills in a timely manner. In May 1986, he filed a supplemental request for hearing contending that the employer had failed to provide updated medical reports. In July 1986, a Determination Order issued on the claim. On August 12, 1986, the Hearings Division notified the parties of a December 8, 1986 hearing date. Claimant subsequently filed a second supplemental request for hearing challenging the July 1986 Determination Order.

In September 1986, the parties entered into a

Stipulation and Order settling the outstanding issues concerning medical bills, while expressly reserving claimant's right to litigate issues arising from the July 1986 Determination Order. The Stipulation and Order was approved and signed by the Referee.

On December 8, 1986, the employer appeared for the scheduled hearing. Claimant did not appear. The Referee entered an Order of Dismissal which provided that the order would be reconsidered if, within 30 days, claimant submitted a written request setting forth a good and sufficient explanation of his failure to appear at the scheduled hearing.

Claimant's counsel timely responded by letter with an accompanying affidavit from one of his employees. The affidavit stated that the hearing had been removed from the attorney's office docket by the employee because of a similarity with an earlier case wherein an interim stipulation had resulted in postponement of the hearing and transfer of the pending issues to inactive status.

On reconsideration, the Referee noted that the Stipulation provided: "HOWEVER, CLAIMANT'S REQUEST FOR HEARING IS NOT DISMISSED AS TO THE ISSUES ARISING FROM THE DETERMINATION ORDER OF JULY 1, 1986." The Referee concluded that the clear import of the Stipulation was that claimant wished to preserve his hearing date. The claimant's motion to set aside the Dismissal Order was denied.

On review, claimant agrees that resolution of this matter depends upon the wording of the Stipulation. Claimant, however, relies upon language appearing directly above the Referee's signature which states: "IT IS SO ORDERED AND THE HEARING SHALL BE SET AS TO THE ISSUES ARISING FROM THE DETERMINATION ORDER." Claimant argues that this language establishes that hearing on the remaining issues remained to be set. Claimant's counsel further argues that, based upon this language, it was reasonable for his employee to assume that there would be a new hearing set on the remaining issues.

Following our de novo review, we are persuaded that claimant has established good cause for his failure to appear at hearing. See OAR 438-06-070. Accordingly, this matter is remanded to the Hearings Division for a hearing on the merits.

ORDER

The Referee's Order on Reconsideration dated January 5, 1987 is reversed, and this case is remanded to the Hearings Division for action consistent with this order.

ROBERT L. PIEPER, Claimant
Cash R. Perrine, Claimant's Attorney
Cowling & Heysell, Defense Attorneys
Davis, et al., Defense Attorneys

WCB 85-15930 & 86-06073
November 10, 1987
Order on Reconsideration

Claimant has requested reconsideration of that portion of our Order on Review dated October 19, 1987, that found claimant's low back condition not compensable. Claimant argues that EBI Companies verbally accepted responsibility for claimant's low back condition.

In support of his argument, claimant points the Board to an unsigned handwritten chart note that states, inter alia: "EBI authorized surgery." On this record, we are not persuaded that EBI

verbally accepted responsibility for claimant's low back condition. Moroever, had we found otherwise, we would still not find that EBI had accepted responsibility. An insurer is responsible only for those conditions that it specifically accepts in writing. Johnson v. Spectra Physics, 303 Or 49, 55-56 (1987); ORS 656.262(9).

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, we adhere to and republish our prior order as supplemented herein, effective this date.

IT IS SO ORDERED

RONALD D. CHAFFEE, Claimant
Harper, Leo & Hollander, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-03983
November 12, 1987
Order Denying Motion for Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated October 16, 1987. Specifically, the insurer asks that we eliminate that portion of the order that remanded the claim to the Evaluation Division.

The insurer's request for reconsideration was mailed on November 5, 1987. However, on or about October 22, 1987, claimant had petitioned for judicial review of the Board's order. Although it is possible to withdraw an order for reconsideration after the filing of a petition for judicial review with the Court of Appeals, Dan W. Hedrick, 38 Van Natta 208, 209 (1986), we exercise this authority rarely.

Accordingly, the request is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

ELWIN D. DISHNER, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 85-0103M
November 12, 1987
Own Motion Order on Reconsideration

Claimant and the SAIF Corporation have requested reconsideration of the Board's August 26, 1987 Own Motion Order which declined to determine the extent of claimant's right arm permanent disability stemming from a January 1976 compensable left arm injury. SAIF joins in claimant's request that the Board rate the extent of claimant's right arm and shoulder disability. Under these circumstances, we conclude that a redetermination would be appropriate. Accordingly, on reconsideration, our prior order is hereby withdrawn.

Following our review of this record, we are persuaded that claimant has sustained a permanent loss of use or function of his right arm due to his compensable injury in an amount greater than the scheduled permanent disability he has previously received. We further conclude that he is entitled to an additional award of scheduled permanent disability for loss of use or function of the right arm in an amount equal to 35 percent. As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $500.

IT IS SO ORDERED.

RICHARD N. FISHER, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-06613
November 12, 1987
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of that portion of Referee Leahy's order that set aside its denial of claimant's ongoing course of chiropractic and physical therapy treatment. The issue is medical services.

After our de novo review of the record, we agree with the employer that its denial should be reinstated. The medical record strongly preponderates in favor of the conclusion that the ongoing treatments are not reasonable and necessary. Claimant's testimony indicates that he receives no material curative or palliative benefit from the treatments. We conclude, therefore, that beginning on the date of the employer's denial, the chiropractic and physical therapy treatments administered through Dr. Christensen's office were not compensable. See ORS 656.245(1); Gerald W. Hannah, 38 Van Natta 109, 112 (1986).

ORDER

The Referee's order dated February 10, 1987 is reversed in part. The self-insured employer's denial dated August 15, 1984 is reinstated and upheld.

ROGER D. HAYES, Claimant
Brian R. Whitehead, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 86-09128
November 13, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Baker's order that upheld the self-insured employer's denial of his aggravation claim relating to his low back. The employer cross-requests review of those portions of the order that: (1) set aside its denial of medical services relating to claimant's low back; and (2) increased claimant's award of unscheduled permanent partial disability for his low back from the 15 percent (48 degrees) granted by Determination Order to 30 percent (96 degrees). The issues are aggravation, medical services and extent of disability.

The Board affirms the order of the Referee on the aggravation and medical services issues. We reverse, however, on the issue of extent of disability.

Claimant injured his low back in June 1984 in the course of his employment as a maintenance worker for a cannery when he lifted a heavy pump. The injury was diagnosed as a lumbar strain and claimant was treated conservatively by Dr. Boughn, a family practitioner. Dr. Boughn released claimant for work in November 1984. Claimant did not think that he was ready to return to work and threatened to sue Dr. Boughn if he reinjured himself. Dr. Boughn then withdrew his work release and terminated care of claimant.

In December 1984, a panel of the BBV Medical Services examined claimant and agreed with Dr. Boughn that claimant was medically stationary and could return to work. They recommended that claimant avoid repetitive lifting and stooping or lifting in awkward positions.

Claimant returned to light work in January 1985 and to regular work the following month. In March 1985, however, he reported an increase in low back pain and left work again. BBV Medical Services again examined claimant and indicated that he had aggravated his condition. They also noted, however, that claimant exaggerated his symptoms throughout the examination.

Claimant treated conservatively with Dr. McIntyre, a family practitioner, until September 1985, when Dr. McIntyre declared him medically stationary. Claimant then began treating with Dr. Wilson, a chiropractor, on referral from his attorney. Dr. Wilson began a course of frequent chiropractic manipulations.

In February 1986, claimant was examined by Dr. Peterson, a consulting chiropractor. He found no objective evidence of injury or impairment and noted many inconsistencies suggestive of malingering. He rated claimant's impairment at zero. Dr. Schilperoot, an orthopedic surgeon and one of the doctors comprising the BBV Medical Services panel, disagreed and indicated that there were some possible objective signs of impairment. He cited a slight decrease in the circumference of claimant's thighs as one example.

Dr. Wilson declared claimant medically stationary in May 1986 and indicated that claimant should avoid lifting more than 25 pounds, avoid repetitive bending or stooping and avoid lifting below his knees or above his shoulders. The claim was closed by Determination Order in June 1986 with a 15 percent unscheduled award. Claimant appealed the Determination Order.

In August 1986, Dr. Wilson rated claimant's low back impairment due to the industrial accident as moderately severe. In October 1986, Dr. Bolin, a consulting chiropractor, opined that claimant's ongoing low back symptoms were due mostly to poor posture and obesity. He rated claimant's low back impairment as a result of the industrial accident as minimal or none.

At the hearing, claimant indicated that he continued to experience low back pain which he attributed to the industrial accident. He said little about any restrictions because of his pain. Dr. Mead, another member of the BBV Medical Services panel, and Dr. Peterson, the consulting chiropractor, both also testified and rated claimant's impairment at zero.

Citing the restrictions imposed by Dr. Wilson in his May 1986 report, the Referee increased claimant's award of unscheduled permanent partial disability from 15 percent to 30 percent.

In rating the extent of disability for claimant's low back, we consider his physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984). Claimant was 29 years old at the time of the hearing and is a high school graduate. His entire work life has been in the cannery in a variety of positions.

After our de novo review of the medical and lay evidence, we conclude that claimant's low back impairment as a result of the industrial accident is in the minimal range.

Exercising our independent judgment in light of this level of impairment and the relevant social and vocational factors, we conclude that an award of 48 degrees for 15 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury. We, therefore, reverse the increase granted by the Referee and reinstate the award granted by Determination Order.

ORDER

The Referee's order dated December 23, 1986 is reversed in part. Those portions of the order that increased claimant's award of unscheduled permanent partial disability and an attorney fee payable from this increased compensation are reversed. The award by Determination Order of 48 degrees for 15 percent unscheduled permanent partial disability is reinstated and affirmed. Claimant's attorney is awarded $200 for services on Board review on the medical services issue, to be paid by the self-insured employer.

MARGARETTE I. SCHAFFER-WRIGHT, Claimant
Martin J. McKeown, Claimant's Attorney
Cummins, et al., Defense Attorneys

Own Motion 87-0594M
November 16, 1987
Own Motion Determination on Reconsideration

Claimant has requested reconsideration of the Board's October 19, 1987 Own Motion Determination which: (1) found that the Board had jurisdiction to close claimant's bilateral foot claim; (2) awarded temporary total disability from June 2, 1986 through July 13, 1986; and (3) declined to award additional scheduled permanent disability. Asserting that matters related to the issues addressed in our prior order are presently pending before the Hearings Division, claimant contends that the Board should have deferred action until the issuance of the Referee's order. In addition, she seeks an award of temporary partial disability.

The request for reconsideration is granted and our prior order withdrawn. Upon further review, for the reasons discussed in our previous order, we continue to find that the Board has jurisdiction to close claimant's claim pursuant to ORS 656.278. Furthermore, we adhere to the Board's previous findings concerning claimant's entitlement to temporary and permanent disability benefits.

Finally, as emphasized in our prior order, we render no opinion concerning the issues currently pending in WCB Case No. 86-13929 or the compensability of the conditions and services denied by the self-insured employer in July 1987. As previously discussed, these issues are entirely subject to the jurisdiction of the Hearings Division. Upon resolution of these issues, should the parties desire further own motion relief, they are requested to so advise the Board. Claimant's current request for temporary partial disability shall be deferred, pending resolution of the forthcoming hearing.

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

IT IS SO ORDERED.

CARL A. ANFORA, Claimant
Bischoff & Strooband, Claimant's Attorneys
Mitchell, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 85-03807, 85-03808, 85-06955 & 85-06956
November 19, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Anfora v. Liberty Communications, 86 Or App 9 (1987). We have been instructed to reinstate the Referee's order that found claimant's present back disability attributable to a "new injury" suffered while working for Cable Communications in 1984.

Pursuant to the court's mandate, the Referee's order is reinstated. Accordingly, Argonaut Insurance's February 6, 1985 denial, on behalf of cable communications, is set aside and the claim is remanded to Argonaut for processing according to law.

IT IS SO ORDERED.

CHARLOTTE J. JOHNSON, Claimant
Coons & Cole, Claimant's Attorneys
David Force, Attorney
David Horne, Defense Attorney
Moscato & Byerly, Defense Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-02119, 83-02685 & 83-10719
November 19, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Johnson v. Spectra Physics, 87 Or App 60 (1987). The Supreme Court concluded that EBI Companies had received notice of claimant's carpal tunnel syndrome claim on November 22, 1982 and did not issue its denial until February 10, 1983. Johnson v. Spectra Physics, 303 Or 49, 59, n. 6 (1987). On remand from the Supreme Court, the Court of Appeals was instructed to determine penalties, if any, against EBI for failing to respond to claimant's carpal tunnel syndrome claim within 60 days. See ORS 656.262(6), and (10). Since the issue of unreasonable delay had never been dealt with by either a Referee or the Board, the Court of Appeals remanded the issue to the Board for proceedings not inconsistent with the court's opinion.

Inasmuch as the issue of EBI's failure to timely respond to the carpal tunnel syndrome claim has never been considered, we conclude that this issue should be remanded to the Referee. See ORS 656.295(5). The Referee is instructed to take further evidence to determine whether EBI's delay was unreasonable and, the amount of penalties and attorney fees, if any, to be assessed against EBI.

Accordingly, this matter is remanded to Referee McCullough for action not inconsistent with the court's opinion and this order.

IT IS SO ORDERED.

KATHRYN I. LOONEY, Claimant
Vick & Gutzler, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB TP-87020
November 19, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Claimant and the third party have agreed to settle claimant's cause of action for $18,000. The paying agency's lien is presently $7,121.46 and it has set aside a reserve for future medical expenses of $4,000.

The paying agency opposes the current offer. Noting that the third party's liability is "not really in issue," the agency contends that claimant's recovery would be more favorable if she proceeded to trial. Under these circumstances, the agency considers any settlement which does not result in its receiving its full lien amount pursuant to the statutory formula to be unreasonable.

The Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. See ORS 656.587. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement amount appears to be grossly unreasonable. Steven B. Lubitz, 39 Van Natta 809 (September 24, 1987); Virginia Merrill, 35 Van Natta 251 (1983); Rose Hestkind, 35 Van Natta 250 (1983).

Applying the aforementioned standards to the present record, we find the proposed settlement reasonable. Consequently, the settlement offer of $18,000 is approved. Furthermore, the proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

LOUIS J. SCHWARTZENBERGER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-02190
November 19, 1987
Second Order on Reconsideration

Claimant has requested reconsideration of the Board's July 30, 1987 Order on Reconsideration that modified its July 8, 1987 Order on Review insofar as the amount of claimant's attorney fee award for services at hearing for prevailing on the issue of his psychological treatment was specified as $700. Claimant asserted that he was not notified of the insurer's request for reconsideration of the Board's July 8, 1987 order until the issuance of the Order on Reconsideration. Consequently, on August 17, 1987, the Order on Reconsideration was abated and claimant was accorded an opportunity to provide an additional response. Having received no further response from either party, we have now completed our reconsideration of this matter.

Where claimant finally prevails in a hearing before the Referee or in a review by the Board, the Referee or Board shall allow a reasonable attorney fee. ORS 656.386(1). Furthermore, if a request for Board review is initiated by an employer or insurer, and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to claimant or claimant's attorney a reasonable attorney fee in an amount set by the Board. See ORS 656.382(2).

Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained. In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss these factors should not be taken to mean that they were not carefully considered in determining a reasonable attorney fee. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

In determining claimant's attorney fee awards for services at the hearing for prevailing on the psychological treatment issue and on Board review concerning the defense of this issue, the aforementioned points and authorities were fully considered. On reconsideration, we continue to find that a $700 attorney fee for services at the hearing level and $500 for services on Board review concerning the psychological treatment issue are reasonable.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish the July 30, 1987 Order on Reconsideration, effective this date.

IT IS SO ORDERED.

STEPHEN C. HENSHAW, Claimant
Emmons, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 86-05907 & 86-05908
November 20, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of Referee Emerson's order that: (1) set aside its denial of claimant's low back injury claim; (2) set aside its denial of claimant's occupational disease claim for a left elbow and forearm condition; and (3) awarded claimant's attorney a $2,000 attorney fee for prevailing on the denials. On review, the issues are compensability and attorney fees.

The Board affirms the order of the Referee with the following comment concerning the low back injury claim.

Claimant contends that he injured his low back when he twisted his body after being tripped by a co-worker. The insurer argues that the so-called "aggressor defense" bars claimant from receiving compensation for his low back injury. See ORS 656.005(8)(a). This defense bars compensation for any injury resulting from a claimant's active participation in an assault or combat, which deviates from customary duties and is not connected to a job assignment. Kesson v. Boise Cascade Corp., 71 Or App 545, 548 (1984).

The Referee found that the "aggressor defense" was not applicable in this case. In reaching this decision, the Referee indicated that claimant's co-worker did not testify to being kicked by claimant.

After a thorough review of the transcript, we find that the co-worker did, in fact, testify that the claimant "kind of kicked" him in the leg, and that the co-worker felt claimant did so "on purpose." Nevertheless, the record as a whole does not establish the type of

active participation in an assault or combat addressed by ORS 656.005(8)(1). We, therefore, affirm the Referee's decision that the "aggressor defense" does not bar claimant from receiving compensation for his low back injury.

Furthermore, we find the compensability issues in this case to have been of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated March 16, 1987 is affirmed. Claimant's attorney is awarded $500 for services on Board review concerning the compensability issues, to be paid by the insurer.

RICHARD R. INGALLS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-03202
November 20, 1987
Interim Order of Remand

Claimant has requested Board review of Referee Wasley's October 10, 1986 order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a left shoulder injury from 50 percent (160 degrees), as awarded by a Determination Order, to 70 percent (224 degrees). Hearings concerning this matter were convened on September 19, 1986 and October 2, 1986. Each was electronically recorded.

Following claimant's request for review, a transcription of the proceedings was requested. See ORS 656.295(3). However, the reporter who recorded the hearings has refused to comply with his statutory and contractual obligation to provide a transcript. The Board is persuaded that a hearing transcript is presently unobtainable. Furthermore, the parties are unable to reach an agreement concerning the testimony given at the hearings.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. See ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to Referee Wasley with instructions to reconvene a hearing. At this new hearing, the parties shall be entitled to present evidence, either testimonial or documentary, concerning the issues that were addressed at the prior hearings. This evidence should pertain to claimant's current condition and other relevant circumstances, as each exists as of the date of the reconvened hearing.

We retain jurisdiction over this matter. Upon completion of the hearing, Referee Wasley shall obtain and certify a copy of the transcript of the hearing to the Board. The transcript should be provided to the Board within 30 days of the hearing. In addition, Referee Wasley shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon his prior order. Once the Board receives the transcript, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

HAROLD B. BATES, Claimant
Bottini & Bottini, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 86-13180
November 24, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Galton's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for his back condition; (2) upheld the employer's "de facto" denial of claimant's medical services claim for his current treatment; (3) declined to award additional interim compensation; and (4) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are aggravation, medical services, interim compensation and penalties and attorney fees.

We reverse that part of the order that found that claimant was not entitled to additional interim compensation, penalties and attorney fees. We affirm the remainder of the Referee's order.

The employer denied the claim on September 9, 1986. At that time, it had paid interim compensation through September 3, 1986. Claimant received his interim compensation benefit payments in two week intervals. The next payment was not due until after September 9th, the date of denial. The employer contends that claimant is not entitled to payment of interim compensation after September 9, 1986 because it is required to pay compensation only until the claim has been accepted or denied. Therefore, the employer argues that it was not required to pay for the period between the last day interim compensation was actually paid, September 3, and the date of the denial, September 9. We disagree.

ORS 656.262(4) provides that the first installment of compensation shall be paid no later than the 14th day after the employer has notice or knowledge of the claim. The term "interim compensation" has been used to describe "the benefits that are payable to a claimant no later than 14 days after a claim is filed but before acceptance or denial of the claim." Georgia-Pacific v. Hughes, 85 Or App 362, 365, rev. allowed 304 Or 55 (1987). ORS 656.262(2) construed together with subsections (4) and (5) requires the employer to pay interim compensation payments until the employer denies the claim. Jones v. Emanuel Hospital, 280 Or 147, 151 (1977).

We interpret the phrase "until the employer denies the claim" to mean payment of interim compensation will be paid up to the date of denial. See Stone v. SAIF Corp., 57 Or App 808, 812 (1982); see also Kosanke v. SAIF, 41 Or App 17, 20 (1979). We do not understand that phrase to mean that because interim compensation may be paid in two week installments, that if an installment is not due and a denial is issued, then the employer is not obligated to pay the benefits for the period between the last day actually paid by installment and the date of the denial.

The purpose of interim compensation is to compensate claimant for days not worked and to ensure that insurers promptly process workers' compensation claims. Bono v. SAIF, 298 Or 405, 410 (1984). Claimant had not returned to work prior to September 9, 1986 and is entitled to benefits for the period September 4 through 9, 1986.

Not only is claimant entitled to benefits for the above noted period, he is also entitled to penalties and attorney fees based upon the employer's unreasonable refusal to pay compensation. ORS 656.262(10); see also Jones v. Emanuel Hospital, 280 Or 147 (1977). The employer shall be liable for a penalty in the additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382. ORS 656.262(10).

We conclude that the employer shall pay as a penalty 25 percent of the interim compensation for the period September 4 through 9, 1986. Furthermore, under the circumstances of this case and in light of the factors enumerated in Barbara Wheeler, 37 Van Natta 122, 123 (1985), we conclude that an appropriate attorney fee is $350.

ORDER

The Referee's order dated March 4, 1987 is affirmed in part and reversed in part. Claimant's is awarded interim compensation for the period between September 4, 1986 and September 9, 1986. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $750. For its unreasonable failure to pay compensation, the self-insured employer is directed to pay a penalty equal to 25 percent of the aforementioned award and an insurer-paid attorney fee of $350. The remainder of the Referee's order is affirmed.

CINDY L. BROOKS, Claimant
Brothers, Drew, et al., Claimant's Attorneys
Carl Davis, Ass't. Attorney General
Rick Barber (SAIF), Defense Attorney

WCB 86-12672
November 24, 1987
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing a request for review of a Referee's order by an alleged noncomplying employer, Bill D. Amick, on the ground that the employer did not file an appellant's brief within the time allowed by the briefing schedule. Filing of briefs is not jurisdictional. OAR 438-11-015(1); Elmira K. Satcher, 38 Van Natta 557 (1986). Consequently, the claimant's motion is denied.

Claimant's respondent's brief shall be due 14 days from the date of this order. The employer shall have 14 days from the date of mailing of claimant's respondent's brief within which to file his reply. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

ROY L. JOHNSON, Claimant
Olson Law Firm, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 86-02958
November 24, 1987
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Garaventa's order that increased his award of unscheduled permanent partial disability for his back from the 55 percent (176 degrees) previously granted to 70 percent (224 degrees). Claimant contends that he is entitled to an award of permanent total disability or, in the alternative, to a greater award of permanent partial disability. The issue is extent of disability.

Claimant injured his back in August 1975 in a work-related vehicle accident. A compression fracture at "D11" and a herniated disc at L4-5 were diagnosed. In October 1976, a fusion of the L4-5 interspace was carried out by Dr. Poulson, an orthopedic surgeon. In September 1978, Dr. Poulson declared claimant medically stationary and rated his impairment as mild. The claim was closed by Determination Order in November 1978 with a 15 percent unscheduled award. The award was later increased to 40 percent by stipulation.

Claimant continued to complain of back pain and began treating with Dr. Smith, a neurosurgeon. Dr. Smith found that the fusion was not solid and recommended a repeat operation which was carried out in October 1983. That fusion did not solidify and a third operation performed out by Dr. Smith in July 1984. By early 1985, Dr. Smith noted that the third operation had not been altogether successful in producing a solid fusion mass either. He considered a fourth procedure, but after a number of consulting examinations, decided against it.

In August 1985, Dr. Smith released claimant for vocational rehabilitation activity if it did not exceed the light category. The vocational counselor reported that claimant was very pessimistic about returning to work, saying that "no one in their right mind would hire me," and was only minimally cooperative with vocational efforts. The counselor nonetheless developed vocational leads in the areas of jewelry making and clock repair and arranged interviews for claimant with interested employers. Dr. Smith approved of these jobs as within claimant's physical limitations. Claimant, however, failed to pursue the positions, characterizing the type of work as "tedious." The vocational file was ultimately closed for failure to participate in the return to work plan.

In December 1985, a consulting orthopedic surgeon, Dr. Mandiberg, rated claimant's impairment as in the upper portion of mildly moderate. Dr. Smith disagreed and rated claimant's impairment as severe. The claim was closed again by Determination Order in January 1986 and the award of unscheduled permanent partial disability was increased to 55 percent.

At the hearing, claimant testified that he experiences constant low back pain which radiates into both legs to the knees. He also indicated that he has difficulty lifting more than a few pounds or standing or sitting for extended periods of time.

The Referee concluded that claimant was not entitled to an award of permanent total disability based upon his lack of cooperation with vocational efforts and his failure to follow up on the job prospects developed by the vocational counselor. We agree with this conclusion. See ORS 656.206(3). The Referee, however, did increase claimant's unscheduled award from 55 to 70 percent. Claimant argues that he is entitled to a greater award.

In rating the extent of unscheduled permanent partial disability for claimant's back, we consider the permanent impairment as reflected in the medical record and the testimony at the hearing and and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules

as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984). Claimant was 40 years old at the time of the hearing and has a ninth grade education. His work experience has been relatively varied and has included jobs as a construction worker, truck driver, janitor, welder, and forklift driver.

After our de novo review of the medical and lay evidence, we conclude that claimant's back impairment is in the severe range. Exercising our independent judgment in light of this level of impairment and the relevant social and vocational factors, we conclude that an award of 272 degrees for 85 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury. We, therefore, increase the award granted by the Referee by 15 percent (48 degrees).

ORDER

The Referee's order dated January 14, 1987 is modified in part. In addition to the award of unscheduled permanent partial disability granted by the Referee, claimant is awarded 15 percent (48 degrees), giving him a total award to date of 85 percent (272 degrees). Claimant's attorney is awarded 25 percent of the increased compensation granted by this order as an attorney fee. However, claimant's total attorney fee for hearing and on Board review concerning this issue shall not exceed $3,000. The remainder of the Referee's order is affirmed.

ROBERT E. PLASCHKA, Claimant
Peter E. Baer, Claimant's Attorney
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Own Motion 87-0372M
November 24, 1987
Own Motion Order Referring for Consolidated Hearing

Claimant has requested that the Board exercise its own motion authority and reopen claimant's claim related to his 1978 injury. Claimant's aggravation rights have expired.

Claimant specifically seeks an order from the Board designating a paying agent until resolution of the upcoming hearing. The Board declines to grant this request. See William C. Dilworth, 38 Van Natta 1283 (1986), Robert L. Trump, 39 Van Natta 314 (1987), and William H. Wilson, 39 Van Natta 365 (1987).

Claimant has a request for hearing pending in WCB Case Nos. 87-14895 and 87-14896, which have been consolidated for hearing. We conclude that it would be in the best interest of the parties to consolidate the matters. In addition to taking evidence on the issues raised in WCB Case Nos. 87-14895 and 87-14896, the Referee shall take evidence on whether claimant's current condition is related to the 1978 injury, and whether the condition has materially worsened so as to justify reopening. At the conclusion of the hearing, the Referee shall forward to the Board a recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case Nos. 87-14895 and 87-14896.

IT IS SO ORDERED.

THOMAS S. WILLIAMSON, Claimant
Rossi & Borneman, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 86-11976 & 86-13031
November 24, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's October 29, 1987 Order on Review in which we affirmed the Referee's finding that Weyerhaeuser Company, self-insured employer, rather than the SAIF Corporation, was responsible for claimant's neck and upper back condition. Specifically, claimant requests an attorney fee for his counsel's services on Board review.

At hearing, the issues included compensability of continuing chiropractic care as well as responsibility for claimant's current neck and upper back condition. Compensability was raised as an issue as a result of Weyerhaeuser's July 30, 1986 denial of further chiropractic treatments as "not reasonable or necessary."

The Referee found the continuing treatments to be compensable and, therefore, set aside Weyerhaeuser's July 30, 1986 denial. The Referee also upheld both Weyerhaeuser's September 4, 1986 denial of an aggravation claim and SAIF's September 12, 1986 denial of a "new injury" claim. He awarded claimant a $1,400 attorney fee, to be paid by Weyerhaeuser, for prevailing on a denied medical services claim.

On Board review, Weyerhaeuser did not question the Referee's conclusion regarding the compensability of the chiropractic treatments. Rather, it asserted that SAIF was responsible for claimant's current neck and upper back problems. In response, claimant submitted a brief arguing that the Referee's responsibility finding should be affirmed. In the alternative, claimant argued that SAIF was responsible for his current condition. We affirmed the Referee's order.

The facts of this case are notably similar to those presented in Robert L. Montgomery, 39 Van Natta 469 (1987). Here, as in Montgomery, no paying agent has been designated under ORS 656.307. Thus, the issue of compensability has not formally been conceded. Claimant has successfully defended the Referee's finding that Weyerhaeuser is responsible for treatments relating to his neck and upper back condition. Claimant has actively participated in these proceedings in order to protect his right to compensation. See ORS 656.382(2). After further consideration, we conclude that claimant is entitled to an attorney fee. See Robert L. Montgomery, supra.

Accordingly, the request for reconsideration is granted and our October 29, 1987 Order on Review is withdrawn. On reconsideration, as modified herein, we republish and adhere to our October 29, 1987 order, effective this date. Considering claimant's attorney's efforts expended and the results obtained, we conclude that a reasonable attorney fee for services on Board review is $400, to be paid by Weyerhaeuser Company.

IT IS SO ORDERED.

PETER G. JEBENS, Claimant
Cash Perrine, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-09843
November 27, 1987
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Gary N. Peterson's order that upheld the insurer's denial of his request for authorization for surgery relating to his low back. The issue is medical services.

The Board affirms the order of the Referee with the following comment. We place no special weight on the opinion of Dr. Nichols as he, notwithstanding the opinion of the Referee, was not a treating physician. We rely, in reaching this result, on the fact that all of the physicians that examined the claimant -- with the exception of Dr. Ames -- believed that surgery would not be productive and that Dr. Ames' letter of July 29, 1986, while reporting that he had consented to performing surgery at the claimant's request, did not explain why he was willing to do so although he had earlier opined that surgery was not indicated.

ORDER

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

WILMA L. HOMSLEY, Claimant
Peter O. Hansen, Claimant's Attorney
Stoel, Rives, et al., Defense Attorneys

WCB 85-14184, 85-13241 & 86-10473
November 27, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Neal's order that upheld the self-insured employer's denials of claimant's occupational disease claim for carpal tunnel syndrome and claimant's aggravation claim for a compensable back and neck injury. The employer cross-requests review of that portion of the order which set aside its denial of claimant's mental stress claim. The issues are whether: (1) claimant's stress claim is compensable; (2) claimant suffered an aggravation of her compensable injury; and (3) claimant's carpal tunnel syndrome is work related.

We find that claimant's stress claim is not compensable and affirm the remainder of the Referee's order.

Since the mid-1960's, claimant has sought medical treatment for numerous physical complaints. She has described pain, tension, spasms, irritation, tingling and numbness involving her entire body. Objective findings have been essentially normal. Claimant began working as a "parts assembler" for this employer in 1980, soon after she separated from her husband. Her husband returned home shortly before she stopped coming to work in 1985.

For the first 18 months that claimant worked for this employer, her attendance, production and quality of work were acceptable. In December 1982 claimant sustained a compensable injury to her back and neck. Dr. Cherry, orthopedist, diagnosed low back and neck strain. Claimant returned to her regular work. A Determination Order awarded time loss but no permanent disability. She attempted to reopen her claim in July 1983 and again in October 1983. The employer denied these claims for aggravation. Claimant requested a hearing and took leave from work under the employer's medical benefits policy.

Claimant continued to treat with Dr. Cherry. He referred claimant to Dr. Berkeley, neurosurgeon, who ordered a myelogram and a CT scan. The results of these tests were normal. Claimant was examined by Dr. Langston, orthopedist, and panels of the Orthopaedic Consultants. They all diagnosed severe functional overlay on normal objective findings. The Consultants recommended a psychiatric examination.

On January 24, 1984, Dr. Parvaresh, psychiatrist, performed an evaluation of claimant. Claimant related vague physical symptoms that did not follow any anatomic or physiologic pattern. She attributed her condition to her 1982 injury. Dr. Parvaresh, however, concluded that claimant suffered a long-standing history of psychiatric disorder manifested by ongoing emotional difficulties, anxiety tension, and psychosomatic disorder which were the same before her 1982 injury.

After a hearing on March 21, 1984, the Referee awarded claimant additional time loss compensation, but no permanent disability. In addition, the aggravation denials were upheld. The Board affirmed the Referee's order, as did the Court of Appeals.

Claimant returned to regular work in August 1984. Dr. Berkeley placed restrictions on prolonged sitting or repetitive bending and lifting. Claimant's manager started claimant as if she was newly hired. She was placed in a training program and her production quota was 20 percent less than that for trained assemblers. In September, claimant complained of aches and pains and asked to work half days. Her manager requested a physician's statement which claimant did not obtain. Claimant's performance review in January 1985 showed her production was below the standard for new employees. Her manager gave her a written job warning and explained the expected production quota.

In February 1985 claimant returned to Dr. Cherry, complaining of numbness and backache. She attributed her numbness to her 1982 injury. Dr. Cherry found her grip strength and reflexes normal. Dr. Berkeley ordered an EMG and nerve conduction studies. The results of these studies were normal. In July 1985, claimant returned to Dr. Berkeley with complaints of leg cramps and numb fingers. He found nothing new upon examination.

In August 1985, claimant complained to her manager about not receiving a new job as an inspector. Claimant had not applied for the job and, in fact, the job was being phased out. Claimant's manager explained that the job also exceeded Dr. Berkeley's restrictions. A few days later, claimant complained to the employer's "Human Resources Specialist" that her manager had overlooked her by not giving her the inspector job and delaying her semi-annual performance review. Claimant thought her manager treated her poorly because she was slow. Later that day, claimant received her performance review, indicating that her production was below standard. Claimant attributed her poor performance to her 1982 injury.

On September 18, 1985, Dr. Woods, an industrial medicine specialist, examined claimant. He concluded that her complaints were not work related. Nonetheless, he suggested that her job be modified. Thereafter, the employer modified claimant's job to half time assembly and half time computer entry work. This plan was approved by Drs. Wood, Berkeley and Cherry.

On October 8, 1985, after having called in sick at work, claimant was involved in a motor vehicle accident in which she "whiplashed" her neck. The emergency room doctor diagnosed cervical strain, but the x-rays and CT scan were normal. Claimant was not excused from work. However, contending that her neck injuries totally disabled her from working, she did not return to work after the accident.

Shortly thereafter, claimant went to Dr. Berkeley for complaints of neck and hand pain. Although Dr. Berkeley could find no objective evidence for claimant's symptoms, she was restricted from her regular work activities. On October 25, 1985, claimant filed a claim alleging that her stress condition arose out of or in the scope of her employment, causing either an injury or an occupational disease.

On November 14, 1985, claimant was released to work, but did not return. Thereafter, claimant's manager notified claimant that if she did not promptly return to work, she would be terminated. When claimant did not return to work she was terminated for job abandonment. Later in December, claimant applied for leave under the employer's medical benefits policy as she had done in 1983-84. Her application was rejected.

Five months later, which was three weeks before hearing, claimant was first evaluated by Dr. Colistro, psychologist. Although Dr. Colistro's associate, a mental health specialist, actually performed the evaluation, Dr. Colistro signed the report. Dr. Colistro has treated her on only one occasion; claimant, however, considers him her "treating" physician. Claimant stated that when she returned to work in 1984: (1) she was not given duties appropriate to her physical abilities; (2) she had not received adequate training; and (3) her manager harassed her to force her to quit work. Claimant thought she was denied expected raises and promotions and thought she should have gotten the inspector job, even though it was being phased out and exceeded Dr. Berkeley's restrictions.

Dr. Colistro concluded that claimant's symptoms were solely related to physically inappropriate work and harassment, which had occurred at work. Yet, Dr. Colistro admitted he only reviewed a small portion of claimant's medical records and none of her employment records. Furthermore, the only background that was obtained in order to evaluate claimant's psychological condition was claimant's recollection of work events. There was no notation of past or ongoing marital tension, anxiety and depression, which had been recorded previously by other physicians.

Dr. Klein, psychiatrist, evaluated claimant on June 3, 1986. Dr. Klein reviewed all medical and employment records, performed a complete examination and wrote a well-reasoned report. In testifying by means of deposition, Dr. Klein agreed with Dr. Parvaresh that claimant had a long-standing personality disorder. Moreover, Dr. Klein concluded that claimant's psychological problems were not a result of her 1982 injury or work exposure.

Dr. Klein attributed most of claimant's stress to her marital relationship. After a 5 year separation, claimant's husband unexpectedly returned in November 1985. Claimant abandoned her job one month later. Dr. Klein thought it was

significant that claimant's husband accompanied her to the interview and talked for claimant despite Dr. Klein's objections.

According to Dr. Klein, claimant's symptoms included marital discord, somatic overfocus, failure to finish school, social withdrawal, hysterical weakness, nonanatomical sensory loss, passive-aggressive interactional behaviors, and hysterical tension. Dr. Klein concluded that none of claimant's symptoms were related to the 1982 injury or exacerbated by her employment.

Dr. Colistro changed his opinion at hearing, after hearing all the facts concerning claimant's medical and employment history. He denied that any job harassment caused the reported anxiety and depression. Rather, Dr. Colistro testified that claimant's 1982 injury alone caused the 1986 condition. He theorized that the injury started a cycle of physical adjustment problems at work. Dr. Colistro did not explain why claimant was able to return to regular work for an entire year before experiencing problems.

Claimant contends her job stress was caused by physically inappropriate work, inadequate training and harassment. Although the Referee found claimant misperceived the cause of her stress, she compared claimant's work stressors to her off-work stressors and determined that her work stress caused her psychological disorder. The Referee was persuaded by the opinion of Dr. Colistro. We disagree.

The medical evidence establishes that claimant had a preexisting personality disorder. Thus, for claimant to establish her claim for job stress, she must prove by a preponderance of the evidence that she suffered a worsening of her psychological condition and that her work exposure was the major contributing cause of that worsening and her resulting disability. Weller v. Union Carbide, 288 Or 27, 35 (1979).

The only medical opinion that supported the theory that claimant's work activities worsened her preexisting psychological condition was rendered by Dr. Colistro. When there is a dispute between medical experts, more weight is given to those medical opinions which are both well reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986). We find that the opinions of Drs. Parvaresh and Klein meet both criteria and therefore, give them great weight. We give little weight to Dr. Colistro's opinion because he fails to explain how his "cycle of physical adjustment" theory, formed at the hearing, is consistent with the fact that claimant returned to regular work for a full year before her problems began.

Stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from objectively existing conditions of the worker's employment and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v SAIF, 296 Or 145, 166 (1983). In the present case, the record does not meet this standard. We are not persuaded that claimant's work conditions, when compared to those outside of her employment, were the major contributing cause of her mental condition.

When the degree of stress from claimant's marital relationship, the October 1985 motor vehicle accident, and its

sequela are compared to the stress she encountered at work, it is apparent that claimant's nonemployment conditions were more significant than conditions at work. Thus, the record establishes that claimant's employment was not the major contributing cause of her mental condition.

Accordingly, claimant failed to prove that her work was the major contributing cause of her psychological condition, or its worsening.

ORDER

The Referee's order dated January 8, 1987 is affirmed in part and reversed in part. The self-insured employer's denial of claimant's stress claim is reinstated. The remainder of the Referee's order is affirmed.

STANLEY C. PHIPPS, Claimant
Aitchison, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Cliff, Snarskis, et al., Defense Attorneys

WCB 84-01838 & 84-02301
November 27, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. SAIF v. Phipps, 85 Or App 436 (1987). We have been instructed to determine the amount of attorney fees payable by the SAIF Corporation for claimant's attorney's participation at the hearing and before the Board.

Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained. In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985).

Following our review of the record and after due consideration of the Wheeler factors, we find that a reasonable attorney fee for claimant's attorney's services at the hearing level is $1,000 and on Board review is $500. Accordingly, claimant's attorney is awarded reasonable attorney fees in the aforementioned amounts, to be paid by the SAIF Corporation.

IT IS SO ORDERED.

DALE ATKINS, Claimant
Coons & Cole, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-06111
December 2, 1987
Order Denying Motion to Stay

The insurer has moved the Board for an order staying that portion of a Referee's order requiring it to pay certain medical services for a 1978 compensable injury as previously directed by a prior Referee's order. Specifically, the insurer asserts that the prior Referee's order has been reversed and that it could not recover its payments for the medical services if it complied with the Referee's order pending Board review. Consequently, the insurer asks that we stay that portion of the Referee's order that requires payment of the medical services.

The insurer's request is contrary to law. ORS

656.313(1) expressly states that the filing of an insurer's request for review shall not stay payment of compensation to a claimant. See also, Robert E. Keys, 39 Van Natta 1132 (November 10, 1987); Harold D. Tallent, 39 Van Natta 345 (1987). At the time of claimant's 1978 compensable injury, medical services constituted compensation and could not be stayed pending appeal. SAIF v. Mathews, 55 Or App 608 (1982); Jane Eder, 39 Van Natta 1087 (October 19, 1987).

Because the insurer asks that the payment of "compensation" to claimant be stayed pending further litigation, we conclude that the motion must be denied. See ORS 656.313(1); SAIF v. Mathews, supra; Jane Eder, supra; Robert E. Keys, supra.

IT IS SO ORDERED.

FRANK DECOUTEAU, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-05809
December 2, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. DeCouteau v. SAIF, 86 Or App 502 (1987). The court has instructed the Board to hold a hearing on "good cause."

Pursuant to the court's mandate, this matter is remanded to Referee Holtan, the Referee who initially considered this case. The Referee is instructed to convene another hearing to consider whether claimant established "good cause" for his hearing request filed more than 60 days, but less than 180 days, after the insurer's denial of his aggravation claim. Thereafter, the Referee shall issue an order regarding this procedural issue. Should the Referee find that "good cause" has been established, he is further directed to render a decision concerning the merits of the claim.

Accordingly, this matter is remanded to Referee Holtan for further actions not inconsistent with the court's opinion and this order.

IT IS SO ORDERED.

JAMES L. LANCE, Claimant
Steven Yates, Claimant's Attorney
Kevin L. Mannix, Defense Attorney
Davis, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
Garrett, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Richard Butler, Defense Attorney
Dean Sandow, Defense Attorney
Marcus Ward, Defense Attorney
Gary Jones, Defense Attorney
Schwabe, et al., Defense Attorneys
Mitchell, et al., Defense Attorneys
David Horne, Defense Attorney
William Beers, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-00279,86-05948, 86-05102, 86-05103, 86-05104, 86-05105, 86-05106, 86-05107, 86-05108, 86-05109, 86-05110, 86-05111, 86-05112, 86-05113,86-05114, 86-05115, 86-05116, 86-05117, 86-05118, 86-05119, 86-05120, 86-05121, 86-05122, 86-05123 & 86-05124

December 2, 1987
Order on Reconsideration

Standard Fire Insurance Company (Standard Fire) has requested reconsideration of the Board's October 8, 1987 Order on Review that affirmed the Referee's finding that it was responsible for claimant's left knee claim. Relying on the reasoning expressed in

Runft v. SAIF, 303 Or 493 (1987), the Board concluded that since Standard Fire had not joined claimant's subsequent employers, it could not assert the last injurious exposure rule defensively to defeat claimant's claim. Thereafter, Standard Fire requested reconsideration, asserting that this matter should be remanded for joinder of the subsequent employers.

On October 19, 1987, the Board's order was abated and the parties were granted an opportunity to respond to Standard Fire's motion within 21 days. Since responses to the motion have been received and because the time to submit further responses has elapsed, we are prepared to consider the motion.

Standard Fire concedes that it, as well as claimant, had the opportunity to join the subsequent employers prior to the hearing. However, it asserts that it chose not to join these employers in reliance on the Court of Appeals' decision in Runft v. SAIF, 78 Or App 356 (1986), which had indicated that the last injurious exposure rule could be used defensively by an insurer without joining potentially responsible subsequent employers. Inasmuch as the Court of Appeals' decision was reversed by the Supreme Court after the hearing in this case, Standard Fire contends that this matter should be remanded to the Referee to allow it an opportunity to join claimant's subsequent employers.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in this request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

Under these circumstances, we are not persuaded that this record has been either "improperly, incompletely or otherwise insufficiently developed." Furthermore, we conclude that Standard Fire has waived joinder of claimant's subsequent employers. See Jay B. Strandquist, 39 Van Natta 761, on recon 39 Van Natta 1116 (October 19, 1987). Consequently, Standard Fire's motion to remand for joinder is denied.

Accordingly, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

RICHARD B. NEHRING, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-12728 & 86-03222
December 2, 1987
Order on Review

Reviewed by Board Members Ferris and Crider.

EBI Companies request review of those portions of Referee Lawrence's order that: (1) set aside its denial of claimant's aggravation claim for his low back condition; (2) upheld CNA Insurance Corporation's denial of claimant's "new injury" claim for the same condition; (3) awarded 40 percent (128 degrees) unscheduled permanent disability for his back condition, in lieu of a Determination Order's award of 10 percent (32 degrees) permanent disability; and (4) awarded claimant an insurer-paid attorney's fee for overturning EBI's denial of responsibility. The issues are responsibility, extent and attorney fees.

We modify that portion of the Referee's order which awarded an attorney fee to be paid by EBI. We agree that claimant is entitled to an insurer-paid fee. We find, however, that the fee should be paid by CNA.

In issuing its denial, EBI contended that claimant's subsequent work activities for CNA's insured were a material contributing cause of his increased symptoms and temporary disability. EBI did not deny the compensability of claimant's condition. Rather, it was merely denying responsibility for his current condition.

Thereafter, claimant filed a "new injury" claim with CNA's insured. CNA denied the claim, contending that there was insufficient evidence to justify a relationship between claimant's current condition and her work activities with CNA's insured. In addition, CNA questioned whether claimant's current condition was compensable.

In a responsibility case, where the issue of compensability has been resolved, a claimant is generally considered a nominal party. Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 571 (1985). As such, a claimant has not "actively and meaningfully participated," and an attorney fee is generally not awarded for services at the hearing level. Petshow, supra. However, where ancillary issues pose a threat to a claimant's entitlement to compensation, an attorney fee award is appropriate. See e.g., National Farms Ins. v. Scofield, 56 Or App 130 (1982); Jerry W. Wine, 38 Van Natta 470 (1986)..

CNA's denial prevented the issuance of a .307 order. Moreover, CNA's denial clearly threatened claimant's ability to ultimately obtain compensation. Under these circumstances, claimant is not considered a nominal party, rather he has "actively and meaningfully participated." Consequently, he is entitled to an insurer-paid attorney fee for services at the hearing level. See ORS 656.386(1).

Where a claimant overcomes an insurer's denial of compensability, even though another insurer is found responsible for compensation, the insurer that denied compensability is responsible for claimant's attorney fee. Karen J. Bates, 39 Van Natta 42, 43 (1987). See Ronald J. Broussard, 38 Van Natta 59, 61 (1986), aff'd mem. Western Employers Insurance v Broussard, 82 Or App 550 (1986).

We agree with the Referee that EBI is responsible for claimant's compensation. Yet, EBI only denied responsibility for claimant's current condition. It was CNA's denial of compensability which prompted claimant's active and meaningful participation at the hearing. Accordingly, pursuant to Bates and Broussard, we find that CNA should be responsible for the attorney fee award.

We affirm the remainder of the Referee's order.

ORDER

The Referee's order dated February 26, 1987 is modified in part. CNA Insurance Corporation's denial is set aside insofar as it denies or purports to deny the compensability of claimant's low back condition. The remainder of CNA's denial is upheld. In lieu of the Referee's $500 attorney fee award to be paid by EBI Companies,

claimant's attorney is awarded $500 for services at the hearing concerning the compensability issue to be paid by CNA Insurance Corporation. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $400 for services on Board review to be paid by EBI Companies.

BRUCE PAPROCK, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 86-01782
December 2, 1987
Order on Reconsideration

Claimant has requested reconsideration of that portion of the Board's November 4, 1987 Order on Review that awarded an insurer-paid attorney fee of $500 for services on review concerning claimant's successful defense of the Referee's finding that claimant's industrial injury claim for right carpal tunnel syndrome was compensable. Specifically, claimant requests that his attorney fee award be increased to $750.

If a request for Board review is initiated by an employer or insurer, and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to claimant or claimant's attorney a reasonable attorney fee in an amount set by the Board. See ORS 656.382(2). Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained.

In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss these factors should not be taken to mean that they were not carefully considered in determining a reasonable attorney fee. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

Here, in determining claimant's attorney fee award, the aforementioned points and authorities were fully considered. On reconsideration, we continue to find that a $500 attorney fee for services on Board review is reasonable.

Accordingly, claimant's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

FLOYD O. WEST, Claimant
Karsten H. Rasmussen, Claimant's Attorney
Les Huntsinger (SAIF), Defense Attorney

WCB 86-06492
December 2, 1987
Order on Review

Reviewed by Board Members Ferris and Johnson.

The SAIF Corporation requests review of Referee Nichols' order that affirmed a Determination Order entered pursuant to ORS 656.325(3), which continued claimant's status as permanently and totally disabled. The issue is whether claimant presently is capable of regularly performing gainful and suitable work.

The Board affirms the order of the Referee.

Claimant failed to timely file his respondent's brief. Nevertheless, he has prevailed over an insurer-initiated request for review. We have previously held that ORS 656.382(2) mandates an insurer-paid attorney fee under such circumstances. Charles D. Barney, 39 Van Natta 646 (1987). Accordingly, we award an attorney fee commensurate with the efforts expended and the results obtained on review. See OAR 438-47-010.

ORDER

The Referee's order dated March 10, 1987 is affirmed. Claimant's attorney is awarded $150 for services on Board review, to be paid by the SAIF Corporation.

PAUL J. WOLF, Claimant
Starr & Vinson, Claimant's Attorneys
William Blitz (SAIF), Defense Attorney

WCB 85-10492
December 2, 1987
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of those portions of Referee Gruber's order that: (1) declined to award permanent total disability; (2) increased claimant's unscheduled permanent disability award for the low back from 35 percent (112 degrees), as awarded by Determination Orders and a stipulation, to 80 percent (256 degrees); (3) affirmed an award by Determination Order of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg; and (4) declined to award an extraordinary attorney fee. The issues are permanent total disability and attorney fees.

The Board affirms the order of the Referee with the following comment concerning the issue of permanent total disability.

The Referee declined to award permanent total disability solely on the basis that claimant allegedly had not made reasonable efforts to lose weight. We agree that claimant is not permanently and totally disabled, but for reasons other than that stated by the Referee.

It is the employer's burden to prove that a claimant has failed to follow medical advice to lose weight. Nelson v. EBI Companies, 296 Or 246, 252 (1984). In order to meet that burden, an employer must show that a claimant "was given a specific weight loss program which he failed to follow for reasons within his control." Lee v. Freightliner Corp., 77 Or App 238, 244 (1986).

Here, claimant did not fail to follow a "specific weight loss program." To the contrary, he participated in at least one weight loss program for approximately two college quarters. Other weight loss programs were neither prescribed nor refused. On this record, we do not find that claimant failed to mitigate the extent of his disability by refusing to follow medical advice to lose weight.

We now turn to the merits of claimant's claim for permanent total disability.

Claimant, 45 at the hearing, sustained a compensable

back injury in May 1980. As a result, he underwent two lumbar laminectomies: in October 1980 and December 1984. Thereafter, his condition was diagnosed as chronic low back pain and obesity.

Following his first surgery, claimant returned to work as a truck driver. However, by November 1982 he was unable to continue in that capacity. Vocational assistance was undertaken resulting in claimant's successful completion of a gunsmith training program. In the fall of 1984, he began part-time work as a gunsmith, but quit a few months later apparently due to back pain.

Dr. Thompson, claimant's treating physician, testified that claimant was totally physically permanently disabled. Thompson also testified, however, that claimant could perform sedentary work up to four hours a day, provided he could frequently change his position. Dr. Golden, neurosurgeon, felt that claimant was physically capable of performing some kind of work. Dr. Karasek, neurologist, testified:

> "although I think [claimant] may have significant disability, I just do not believe in all medical probability that he is totally disabled." (Emphasis in original)."

Lastly, Dr. Henbest, neurosurgeon, testified that claimant could possibly work up to two hours a day.

The vocational evidence is divided. Mr. Tucker, vocational counselor, testified that claimant could work as a taxi dispatcher, light machine operator, and a gunsmith component assembler. On the other hand, Mr. Williams, vocational counselor, testified that claimant was not employable in "any job."

Claimant has a high school education and has worked as a janitor, cook, cab and truck driver, painter, and gunsmith. He testified that he can drive a car approximately 65 miles without stopping, and that he regularly performs chores including mowing the lawn. In addition, he has an at-home gunsmith workshop. He is able to sit at a work bench and work for 45 minutes without rest.

Although the Referee declined to award permanent total disability, he awarded claimant 80 percent unscheduled permanent disability in lieu of all previous unscheduled awards, and affirmed a 5 percent scheduled permanent disability award for the left leg.

A worker may prove permanent total disability by showing that he is totally physically or medically incapable of performing regular gainful and suitable employment. See Brech v. SAIF, 72 Or App 388 (1985). Permanent total disability need not, however, derive solely from a worker's physical incapacity. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Accordingly, under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

Here, Dr. Thompson is the only medical expert who opined that claimant was totally physically permanently disabled. Yet,

Thompson also felt that claimant could work up to four hours a day. Given claimant's testimony concerning his daily activities and his ability to drive a car, we are more persuaded by the opinions of Drs. Golden and Henbest that claimant is not totally physically permanently disabled.

In addition, the preponderance of the evidence does not establish that claimant is entitled to an award of permanent total disability under the "odd-lot" doctrine. Dr. Thompson restricted claimant to no lifting in excess of 20 pounds, no prolonged standing or sitting, and no bending or stooping. Exercising our independent judgment, based on all the medical evidence and claimant's testimony concerning his physical abilities, we find that claimant's physical impairment is in the range of moderate. At 45 years of age, claimant is relatively young. He is educated through high school and has successfully completed a gunsmith training program. No physician has restricted claimant from performing work as a gunsmith. Lastly, vocational counselor Tucker felt that claimant had transferable skills and was employable.

Accordingly, after our de novo review of the lay and medical evidence, we conclude that claimant is not permanently and totally disabled from regularly performing gainful and suitable employment.

ORDER

The Referee's order dated January 12, 1987 is affirmed as supplemented.

ANDREW R. BOYLE, Claimant
Malagon & Moore, Claimant's Attorneys
Phillip L. Nyburg, Defense Attorney

WCB 86-05084
December 4, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Peterson's order which: (1) upheld the Director's determination that claimant is not entitled to further reimbursement of mileage to and from his vocational rehabilitation training site; and (2) declined to assess penalties and attorney fees for the insurer's late payment of past reimbursable mileage. The issues are mileage reimbursement and penalties and attorney fees. We reverse in part and affirm in part.

We reverse that portion of the Referee's order denying penalties and attorney fees.

There is no dispute that the insurer underpaid claimant for reimbursable mileage travelled during January 1986. From January 2 through January 22, the insurer reimbursed claimant at the rate of 12 cents per mile. However, under OAR 436-120-150(2)(b)(A), which became effective on January 1, 1986, claimant was entitled to reimbursement at the rate of 14 cents per mile. The underpayment was not corrected until December 26, 1986, on which date the insurer issued claimant a check for $25.76.

The Referee concluded that penalties and attorney fees were not warranted because the insurer's delay was apparently inadvertent and did not prejudice claimant in any way. We disagree.

An eligible worker is statutorily entitled to "promptly"

paid compensation. See ORS 656.262(2). Under ORS 656.262(10), an insurer is liable for penalties and attorney fees if it "unreasonably delays" compensation. Neither prejudice nor intentional delay are necessary predicates to the imposition of a penalty and attorney fees. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984).

Here, there is no explanation in the record for the eleven-month delay. Absent an explanation, we conclude that the delay was unjustified and, therefore, unreasonable. See id. Consequently, penalties and attorney fees are appropriate.

We affirm that portion of the Referee's order that refused to award claimant further mileage reimbursement. In so doing, we reject claimant's contention that the Director does not have discretion under OAR 436-120-150 to limit reimbursable mileage. In relevant part, OAR 436-120-150(1) provides that direct worker purchases, such as mileage, be reimbursed insofar as they are "necessary elements of ... training services." Here, the Director properly exercised his discretion in finding that claimant had been sufficiently reimbursed for mileage necessary to his participation in training services.

ORDER

The Referee's order dated March 2, 1987 is reversed in part and affirmed in part. That portion of the order that denied claimant's request for penalties and attorney fees is reversed. As a penalty for its unreasonable delay in making full payment for claimant's reimbursable mileage in January 1986, the insurer is assessed a penalty equal to 25 percent of the underpayment. For prevailing on the penalty issue, claimant's attorney is awarded a fee of $250, to be paid by the insurer. The remainder of the Referee's order is affirmed.

PATRICIA E. HUSTED, Claimant
Michael B. Dye, Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-08507
December 4, 1987
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Seymour's order that rejected her request for awards of permanent partial disability in addition to the 15 percent (22.5 degrees) scheduled permanent partial disability previously granted for the left knee and 20 percent (64 degrees) unscheduled permanent partial disability previously granted for the right shoulder. The issues are extent of scheduled and unscheduled disability.

The Board affirms the order of the Referee with the following comment. Claimant appealed a Determination Order that was issued after the discontinuation of an authorized training program. The primary dispute on Board review is whether claimant had to prove a worsening of her compensable conditions since the time of a stipulation which preceded the latest Determination Order. We need not decide this question because even assuming that claimant's disability is assessed anew after the issuance of the Determination Order, we conclude that claimant has been adequately compensated by the awards previously granted.

ORDER

The Referee's order dated April 14, 1987 is affirmed.

ALVIN L. WOODRUFF, Claimant
Coons & Cole, Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB 85-09473
December 4, 1987
Order Striking Brief Reply

The self-insured employer has moved the Board for an order striking claimant's reply brief. The motion is granted.

Claimant's second request for an extension of time within which to file his appellant's brief was denied. See OAR 438-11-015(3). Consequently, his appellant's brief was rejected as untimely filed. Inasmuch as claimant had failed to file a timely brief, the employer declined to submit a respondent's brief. Thereafter, claimant resubmitted his orginal brief, but entitled it "reply" brief.

Since no respondent's brief has been submitted, there is nothing for claimant to reply to. Moreover, because claimant's appellant's brief was not accepted on timeliness grounds, it will not be considered upon resubmission as a reply brief. Deryl E. Fisher, 38 Van Natta 982 (1986).

Accordingly, claimant's reply brief shall not be considered on review. This matter will now be docketed for Board review.

IT IS SO ORDERED.

PEDRO G. ALCALA, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-05800
December 11, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Holtan's order that upheld the insurer's aggravation and responsibility denials for claimant's allegedly worsened back condition. The issues are aggravation and responsibility.

The Board affirms the order of the Referee with the following comment.

Claimant sustained a compensable back injury in September 1983 while working in Oregon. In March 1986, he sustained a compensable back injury in Washington. He presently seeks to establish the Washington injury as an aggravation of his compensable 1983 injury. At the time of hearing, claimant was receiving temporary disability compensation under his Washington claim.

The insurer issued two written denials. In April 1986, it denied claim reopening on the basis that there had been no "material aggravation." The next month, it denied "responsibility," contending that the Washington injury was a "new injury." At the hearing, however, the insurer's attorney stated:

> "As I -- tried to frame the issues in my opening statement, it really is evident that we're not denying that there was a need for further medical treatment and a period of disability. So we're not denying that there isn't some compensability. It's a question of whose it is."

The Referee found that claimant's aggravation claim "fail[ed] on compensability grounds alone." Consequently, the Referee did not consider the issue of responsibility.

In our view, at the hearing, the insurer's attorney conceded the issue of compensability and sought to defend against claimant's aggravation claim solely on the basis of responsibility. Therefore, it was incorrect for the Referee to have decided the case on compensability grounds alone.

In Miville v. SAIF, 76 Or App 603, 607 (1985), the court established a rule governing responsibility in interstate cases:

> "[W]e conclude that the rationale of Grable [v. Weyerhaeuser Co., 291 Or 387 (1982),] should apply when a claimant has suffered an on-the-job injury in another state for which he has claimed, but has not been awarded, compensation, and the medical evidence is that the original Oregon injury materially contributed to the claimant's present disability, even though the out-of-state injuries contributed independently to the present disability."
>
> "... Accordingly, [the Oregon insurer] remains responsible, if claimant has filed a claim in [another state] that has resulted in a final determination that his condition is not compensable in that state. If claimant has not filed a claim in [another state], or if he has done so and has been awarded compensation, [the Oregon employer/insurer] is not responsible for claimant's present condition." (Emphasis added).

Here, claimant had filed a claim in Washington for his March 1986 back injury and was receiving temporary disability compensation under that claim. Accordingly, pursuant to Miville, supra, the Oregon insurer is not responsible for claimant's present condition.

ORDER

The Referee's order dated February 19, 1987, is affirmed as supplemented.

ANNAMARIA MACIAS, Claimant
Max Rae, Claimant's Attorney
Bottini & Bottini, Defense Attorneys

WCB 87-07960
December 11, 1987
Order of Dismissal

The self-insured employer has requested Board review of Presiding Referee Daughtry's order that allowed claimant to tape record her independent medical examination, but declined to allow her attorney to be present at the examination. In her brief, claimant contends that the employer's request for Board review should be dismissed on the grounds that the Referee's order is not a final, appealable order.

The Referee's order includes appeal rights and is otherwise

in the form of a final order. However, that is not dispositive of the issue of whether the order is reviewable. The courts have held that a decision which neither finally denies a claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Other relevant considerations in determining whether an order is appealable include the reviewing body's interest in avoiding piecemeal review of multiple issues arising in a single case. Harris E. Jackson, 35 Van Natta 1674 (1983). Thus, we have in the past considered procedural rulings by a Referee as interim orders not subject to Board review. See Jackson, supra; Zeno T. Idzerda, 38 Van Natta 428 (1986); Gerald L. Morris, 36 Van Natta 1684 (1984); John Swearinger, 29 Van Natta 269 (1980); Derral D. Kelley, 28 Van Natta 793 (1980).

Here, the Presiding Referee's order neither finally disposed of, nor allowed, a claim. Rather, it is a procedural ruling resolving an issue concerning claimant's participation in a medical examination. Consequently, we lack jurisdiction to consider the issue raised by the request for review. Accordingly, the request for Board review is dismissed.

Finally, claimant requests that we award a reasonable attorney fee for prevailing on the request for dismissal. There is no entitlement to attorney fees where a request for dismissal is filed prior to a decision on the merits. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Leland O. Bales, 38 Van Natta 25 (1986); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985). We, therefore, deny claimant's request for attorney fees.

IT IS SO ORDERED.

JOSEPH L. WOODWARD, Claimant
Francesconi & Cash, Claimant's Attorneys
Cliff, Snarskis & Yager, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-10137 & 85-06339
December 11, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Industrial Indemnity requests review of that portion of Referee Knapp's order that: (1) set aside its denials of claimant's aggravation claim for a back condition; and (2) upheld Safeco Insurance Company's denial of claimant's "new injury" claim for the same condition. The issues are compensability and responsibility.

The Board affirms the order of the Referee with the following comment.

Claimant sustained a compensable back injury in July 1981 while working for Industrial Indemnity's insured. In March 1985, while working for Safeco's insured, he was unable to continue working due to increased back pain.

In finding an aggravation, rather than a "new injury," the Referee found that claimant had sustained a mere recurrence of symptoms relating to his compensable July 1981 injury. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). In addition, the Referee cited to Smith v. SAIF, 302 Or 109 (1986), and stated "claimant need only prove increased symptoms * * *."

At the time of the Referee's order, Smith, supra, was current law. Subsequently, however, the Oregon Supreme Court withdrew its decision in Smith, supra, and reconsidered the matter in Smith v. SAIF, 302 Or 396 (1986). On reconsideration, the Smith court announced that, in aggravation cases, increased symptoms are not compensable without pain or additional disability that results in a loss of earning capacity. 302 Or at 401.

While we recognize the correct standard for aggravation cases, as announced by the later Smith decision, we nonetheless find that the Referee reached the correct result.

In compensability/responsibility cases, the threshold issue is compensability. If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Here, claimant was unable to continue working in March 1985 due to increased back symptoms, thereby resulting in a loss of earning capacity. Accordingly, pursuant to the later Smith decision, claimant has proven a compensable aggravation claim.

Turning to the question of responsibility, in Mirich, supra, the court announced that unless the "new injury" independently contributed to a claimant's disability (i.e., caused a worsening of his underlying condition) then the claimant had sustained a mere recurrence of symptoms and the first employer remained responsible. 81 Or App at 294. Here, after our de novo review of the medical and lay evidence, we find that in March 1985 claimant sustained a mere recurrence of his symptoms relating to his compensable July 1981 injury; not a worsening of his underlying condition. Therefore, the first employer remains responsible for claimant's increased symptoms.

Furthermore, we find that the compensability issue presents a question of ordinary difficulty with the usual probability of success for claimant on Board review. Consequently, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated December 2, 1986 is affirmed as supplemented. Claimant's attorney is awarded $500 for services on Board review, to be paid by Industrial Indemnity.

SHIRLEY S. BAKER, Claimant
Horton & Koenig, Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys
E. Jay Perry, Defense Attorney

WCB 86-06927 & 86-09274
December 15, 1987
Order Denying Motion to Dismiss

Liberty Northwest Insurance Corporation, on behalf of its insured, The Ranch Restaurant, 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 upon all parties. See ORS 656.289(3); 656.295(2).

The Referee's order issued August 31, 1987. Claimant's request for Board review was mailed September 1, 1987 and was received by the Board the following day. A certificate of service submitted with the request indicated that a copy of the request had been mailed to the two employers involved in this case,

Mr. B's and The Ranch Restaurant; to Liberty Northwest, the insurer of both employers; and to counsel for Liberty Northwest/Mr. B's. Liberty Northwest contends that claimant did not perfect her request for review because she did not serve counsel for Liberty Northwest/The Ranch Restaurant and because only one copy of the request was served on Liberty Northwest.

Regarding the first ground for the motion to dismiss, ORS 656.295(2) requires that a copy of a request for review be "mailed to all parties to the proceeding before the referee." "Party" is defined by ORS 656.005(19) as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." Attorneys are not included within this definition. There was no requirement, therefore, that claimant serve counsel for Liberty Northwest/The Ranch Restaurant in order to perfect its request for review.

Regarding the second ground for the motion to dismiss, an insurer is a "party," see ORS 656.005(19), and thus must be served with a copy of the request for review. Only one copy of the request for review was mailed to Liberty Northwest as insurer for both Mr. B's and The Ranch Restaurant. The copy of the request for review, however, referenced both of Liberty Northwest's claim numbers. We conclude that this was sufficient service of Liberty Northwest/Mr. B's and Liberty Northwest/The Ranch Restaurant to satisfy ORS 656.295(2).

In addition to the above reasons for denying the motion to dismiss, we note that claimant's request for Board review was received just two days after the date of the Referee's order. Two days later, on September 4, 1987, the Board mailed a computer generated letter to all of the parties, acknowledging the request for review. We presume that this letter was received by Liberty Northwest within a few days after it was mailed. See John D. Francisco, 39 Van Natta 332 (1987). Liberty Northwest makes no assertions to the contrary.

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "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." (Emphasis added). By virtue of the Board's computer generated acknowledgement letter, we conclude that Liberty Northwest received actual notice of the request for review within 30 days of the date of the Referee's order. The Board, therefore, has jurisdiction to consider claimant's request for review regardless of the sufficiency of claimant's service of copies of the request for review on the parties.

Accordingly, Liberty Northwest's motion to dismiss is denied.

IT IS SO ORDERED.

HAROLD C. KIMSEY, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-06815
December 18, 1987
Order Striking Reply Brief

The self-insured employer has moved the Board for an order striking claimant's reply brief. The motion is granted.

Claimant's appellant's brief was rejected as untimely filed. See OAR 438-11-015(2). Inasmuch as claimant had failed to file a timely brief, the employer declined to submit a respondent's brief. Thereafter, claimant resubmitted his orginal brief, but entitled it "reply" brief.

Since no respondent's brief has been submitted, there is nothing to which claimant could reply. Alvin L. Woodruff, 39 Van Natta 1161 (December 4, 1987). Moreover, because claimant's appellant's brief was not accepted on timeliness grounds, it will not be considered upon resubmission as a reply brief. Deryl E. Fisher, 38 Van Natta 982 (1986).

Accordingly, claimant's reply brief will not be considered on review. This matter shall now be docketed for Board review.

IT IS SO ORDERED.

ANNETTA R. McKINSTRY, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-09657
December 18, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. McKinstry v. Industrial Indemnity, 87 Or App 390 (1987). The court has mandated that claimant's occupational disease claim for a stress-related mental disorder be accepted.

Accordingly, the insurer's July 26, 1985 denial is set aside and the claim is remanded to the insurer for processing pursuant to law.

IT IS SO ORDERED.

JOYCE E. MITTS, Claimant
Kenneth D. Peterson, Claimant's Attorney
Yturri, et al., Defense Attorneys

WCB 87-11662
December 18, 1987
Order of Dismissal (Remanding)

Claimant has requested Board review of Referee Brazeau's November 20, 1987 order. On December 4, 1987, claimant timely mailed her request for Board review. See ORS 656.289(3); OAR 438-11-005(2); 438-05-040(4). That same day, Referee Brazeau issued an Order of Abatement to consider both claimant's and the insurer's Motions for Reconsideration.

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Since the Referee abated his order simultaneously with claimant's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for Board review is

dismissed as premature. This matter is remanded to Referee Brazeau for further consideration.

IT IS SO ORDERED.

ROSE J. PETERSON, Claimant
Charles D. Maier, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney
Rankin, et al., Defense Attorneys

WCB 86-12839 & 86-12003
December 18, 1987
Dismissal of Cross-Request for Board Review

Claimant has submitted a cross-request for review of the Referee's order dated October 16, 1987. Liberty Northwest Insurance Corporation timely mailed a request for Board review on October 29, 1987. Claimant's cross-request for review, dated November 4, 1987, was hand-delivered to the Board on November 30, 1987.

When one party requests a review by the Board, the other party or parties shall have the remainder of the 30-day appeal period and in no case less than 10 days in which to request Board review. ORS 656.289(3). Thus, under the most extreme of circumstances, a cross-request may be effective if submitted within 40 days of the Referee's order. See Robert Casperson, 38 Van Natta 420 (1986).

Inasmuch as Liberty's request for review was mailed 13 days after the Referee's order, claimant had the remaining 17 days of the 30-day appeal period within which to file her cross-request. Claimant's cross-request was dated within 30 days of the Referee's order. However, the cross-request was not filed until some 45 days after the Referee's order. Consequently, the cross-request is untimely.

Accordingly, claimant's cross-request for Board review is dismissed.

IT IS SO ORDERED.

CANDAS J. ROBINSON, Claimant
Moomaw, Miller & Reel, Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 86-10831 & 86-07876
December 18, 1987
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Tenenbaum's order that: (1) upheld the SAIF Corporation's denial of her claim for a right ankle injury; and (2) upheld SAIF's denial of her aggravation claim relating to her left ankle. With her brief, claimant has submitted a letter from her treating physician dated three weeks following the hearing. In addition, she has referred to material from medical journals and a treatise that are not in the record. We treat these submissions as a request for remand to the Referee for further evidence taking. The issues are compensability and remand.

We first note that we have no authority to consider evidence not admitted at the hearing and not a part of the record. Groshong v. Montgomery Ward Co., 73 Or App 403, 406 (1985).

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986). Here, the proferred evidence was reasonably

obtainable prior to hearing. Furthermore, the evidence is merely cumulative in nature. Claimant's request for remand is denied.

On the merits, the Board affirms the order of the Referee.

ORDER

The Referee's order dated March 26, 1987 is affirmed.

MARILYN L. JOHNSON, Claimant
Roll, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-17647
December 23, 1987
Order Dismissing Request for Review and Remanding

Claimant has requested Board review of Referee Huff's November 16, 1987 Interim Order which canceled a previously scheduled hearing and directed that a new hearing notice issue replacing the previously responsible insurer, EBI Companies, with the insurer that had finally been determined to be responsible for the claim, the SAIF Corporation. The hearing concerned claimant's appeal from a December 13, 1985 Determination Order. We have reviewed the request to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither finally denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's "interim" order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the "interim" order preserved claimant's hearing request concerning the Determination Order and replaced the formerly responsible insurer with the insurer who had ultimately been found responsible for the claim.

Inasmuch as further action before the Hearings Division was required as a result of the Referee's order, we conclude that it was not a final appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issues raised by the request for review.

Accordingly, the request for Board review is dismissed. This case is remanded to the Hearings Division for further proceedings consistent with this order and the Referee's Interim Order.

IT IS SO ORDERED.

RONALD D. CHAFFEE, Claimant
Harper, Leo & Hollander, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-03983
December 31, 1987
Second Order Denying Motion for Reconsideration

The insurer has renewed its request that the Board reconsider its Order on Review dated October 16, 1987. Specifically, the insurer again asks that we eliminate that portion of the order that remanded the claim to the Evaluation Division.

As stated in our November 12, 1987 Order Denying Motion For Reconsideration, the insurer's request for reconsideration was filed after claimant had petitioned for judicial review of the Board's order. Noting that we exercise our authority to withdraw an order for reconsideration after the filing of a petition for judicial review with the Court of Appeals only on rare occasions, we declined to do so.

Upon further consideration of the insurer's motion, we continue to deny the request. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

KWITO GIESZLER, Claimant
Bottini, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

Own Motion 86-0528M
December 31, 1987
Own Motion Order and Determination

On August 26, 1987 the Board issued an Own Motion Interim Order which directed the insurer to pay "interim" compensation from August 11, 1987 until claim closure pursuant to ORS 656.278. While the claimant was receiving benefits, the insurer was accorded the opportunity to evaluate claimant's medical and vocational status in response to claimant's contention that he was permanently and totally disabled. Once the insurer completed the aforementioned evaluation or 60 days from the date of the Board's order, whichever occurred first, the Board advised the parties that it would consider claimant's request for permanent total disability.

On November 3, 1987 the insurer submitted a report from Jerome Gillis, a vocational counselor, concerning claimant's current vocational status. The report was dated October 23, 1987. The insurer requested that the Board commence its review of claimant's petition for relief.

Claimant objects to the untimely submission of this report, but waives his right to cross-examination. Contending that his condition worsened on May 20, 1985, claimant asks that his claim be reopened as of that date.

Following our review of this record, we are persuaded that claimant's compensable condition did worsen in 1985 resulting in the September 1985 knee surgery. However, claimant is not entitled to compensation for temporary total disability as he removed himself from the work force several years earlier. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Finally, we agree that the insurer did not timely comply with the Board's interim order. Yet, inasmuch as the Board

exercises continuing jurisdiction over such matters, we see no rational reason for refusing to consider relevant evidence. See ORS 656.278(1). Therefore, the report submitted by the insurer shall be considered. Claimant requests that the Board issue an expedited order and waives his right to cross-examine the insurer's vocational counselor. The insurer's request that the Board refer this matter to a hearing is denied.

Claimant seeks compensation for permanent total disability. Although Dr. Baldwin and the claimant's vocational counselor contend he is permanently and totally disabled, the Board finds the preponderance of the evidence fails to justify such an award. We are persuaded claimant does have the capability of performing light or sedentary work with retraining. However, we also find claimant has evidenced very little motivation to satisfy the odd-lot doctrine of ORS 656.206(3). Claimant's request for permanent total disability must be denied. Claimant's left knee, however, is permanently worse and an appropriate award will be granted. Claimant is hereby granted an additional award for 75 degrees for 50 percent loss of function of the left knee. Amounts paid pursuant to the Board's August 26, 1987 order may not be offset against this award. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $500 as a reasonable attorney's fee.

IT IS SO ORDERED.

BRUCE A. HATLELI, Claimant
Bischoff, et al., Claimant's Attorneys
Malagon & Moore, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney
David Horne, Defense Attorney

WCB 85-02089, 85-04106, 85-07657 & 85-07658
December 31, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Hatleli v. McKay's Inc., 87 Or App 198 (1987). We have been instructed to award an attorney fee for Wausau Insurance's untimely denial of responsibility for claimant's "new injury" claim.

Pursuant to OAR 438-47-010(2), the amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained. In determining the reasonableness of attorney fees, several factors must also be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss these factors should not be taken to mean that they were not carefully considered in determining a reasonable attorney fee. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

Following our review of the record and after consideration of the aforementioned factors, we find that a reasonable attorney fee for claimant's attorney's services in connection with Wausau's late denial is $250. Accordingly, claimant's attorney is awarded $250 as a reasonable attorney's fee for services in connection with the late denial, to be paid by Wausau Insurance.

IT IS SO ORDERED.

CORONDA J. JOHNSON, Claimant
Wilbur C. Smith, Jr., Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys

WCB 85-10405
December 31, 1987
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Tenenbaum's order that: (1) affirmed a prior Determination Order that declined to award any permanent partial disability for a low back injury; and (2) upheld the insurer's denials of claimant's current chiropractic treatments. The issues are extent of permanent disability, medical services and the propriety of the insurer's preclosure denial.

We affirm those portions of the Referee's order concerning the extent of disability and the insurer's November 11, 1986 denial of ongoing medical services. We reverse, however, the Referee's order insofar as it upholds the insurer's September 8, 1986 "pre-closure" denial of "any further medical billings, as of 8-13-86...."

On June 27, 1985, claimant suffered a compensable injury to her lower back when she fell while working on a production line. She consulted Dr. Ferrente, chiropractor, the day after her injury. She received two treatments from him, the first on July 10, 1985 and the second on August 30, 1985.

Claimant became pregnant at the end of August or in early September 1985. She sought treatment from Dr. Rajdev for obstetrical care and back pain. In January 1986, Rajdev concluded that claimant was experiencing a lumbrosacral strain. He recommended she receive temporary disability benefits. Later, claimant underwent a surgical procedure because of a miscarriage.

In February 1986 claimant was involved in an off-the-job car accident which resulted in minimal impairment to her head and neck. She sought treatment from Dr. Novick, chiropractor, for her injuries. In April, Novick first treated claimant for back pain. At that time, Novick became her treating physician and began treating her for her compensable injury of June 1985.

Dr. Ziven, neurologist, performed an examination of claimant on July 17, 1986. He concluded that she was stationary and able to return to her regular work. Thereafter, the insurer denied any further disability payments and medical billings for claimant's low back condition, effective as of August 13, 1986, the date it received Dr. Ziven's report. On September 8, 1986, Dr. Novick released claimant to work with restrictions which he felt precluded her return to regular work. He agreed that she was stationary.

A September 25, 1986 Determination Order awarded temporary total disability, but declined to award any permanent partial disability.

On November 10, 1986, Dr. Novick opined that claimant would need ongoing palliative care and recommended chiropractic treatments one to two times monthly. On November 17, 1986, the insurer issued a second denial letter denying ongoing chiropractic care for claimant's low back condition because it was neither reasonable, necessary nor related to the industrial accident.

On December 3, 1986, the insurer's attorney advised claimant that all temporary disability benefits had been paid through the Determination Order, but that the claimant's ongoing chiropractic treatment was not reasonable, necessary or related to her accepted injury.

On September 29, 1986, Dr. Ziven stated that claimant was experiencing no residual symptoms from her industrial injury. He attributed much of her back pain to her pregnancies, miscarriage and "D&C" procedure. He did not feel that Dr. Novick's chiropractic treatments were useful.

Dr. Howell, osteopath, examined claimant in January 1987, a month after the insurer's attorney's letter and several months after the insurer's preclosure denial. Howell essentially agreed with Dr. Ziven.

Dr. Novick related claimant's pain to her industrial injury. Claimant receives relief from her low back pain and an improvement in mobility as a result of the chiropractic treatments.

The Referee reasoned that too many factors, such as claimant's infrequent and sporadic treatment, intervened between the date of her compensable injury and her need for ongoing chiropractic treatments to allow the injury to be a material contributing cause of her condition. Consequently, the Referee concluded that the treatments were not compensable.

Claimant contends that the insurer's September 8, 1986 denial issued prior to the issuance of the September 25, 1986 Determination Order was an improper preclosure denial of a previously accepted claim. We have previously held that Bauman v. SAIF, 295 Or 788 (1983), does not preclude partial denials for continuing medical services which the insurer has reason to believe are not causally related to the accepted claim. Clyde C. Wyant, 36 Van Natta 1067 (1984). Here, the insurer argues that its denials were proper because they denied medical treatments which were unrelated to claimant's accepted claim. We disagree.

Under Roller v. Weyerhaeuser, 67 Or App 583, 587 (1983), once an insurer has accepted a medical condition it may not deny all medical services related to the claim, prior to closure. However, an insurer may deny claims for specific medical treatments or for aggravation post-closure. Id. The September 8, 1986 denial purported to deny all medical services on the claim after August 13, 1986. The denial did not address any particular course of treatment for any particular condition. Rather, it attempted to cut off, prior to claim closure, all further treatment to which the claimant might be entitled under ORS 656.245. It was therefore too broad and in conflict with Bauman and Roller. It is set aside and medical services shall be paid until a proper denial issued.

The November 17, 1986 denial was issued post-closure and worded much narrower. It did not deny all future medical services but only the "ongoing chiropractic treatment" she was then receiving. Unlike the pre-closure denial, this denial is not in conflict with either Bauman or Roller. Furthermore, the denial is supported by the evidence, which preponderates that claimant's June 1985 injury is not a material contributing cause of her need for ongoing chiropractic care. See Jordan v SAIF, 86 Or App 29, 32 (1987). Consequently, we conclude that the insurer's November 17, 1986 denial of claimant's ongoing chiropractic care was proper.

ORDER

The Referee's order dated February 6, 1987 is affirmed in part and reversed in part. The insurer's September 8, 1986 denial is set aside and the insurer is directed to pay for claimant's chiropractic treatments until November 17, 1986, the date of the insurer's proper denial. Claimant's attorney is awarded $700 for services at the hearing level and $350 for services on Board review concerning this issue, to be paid by the insurer. The remainder of the Referee's order is affirmed.

CHARLES SELFRIDGE, Claimant
Bottini, Bottini & Lehner, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 85-0097M
December 31, 1987
Own Motion Order

Claimant has requested that the Board exercise its Own Motion authority under ORS 656.278 and direct the SAIF Corporation to comply with a July 17, 1985 Own Motion Order on Reconsideration. Pursuant to our prior order, claimant was awarded temporary disability benefits during a certain time period, less any time worked. In addition, claimant's attorney was awarded 25 percent of the increased compensation granted by the order, not to exceed $500.

Specifically, claimant asks that SAIF be assessed a penalty and attorney fee for its alleged noncompliance with our previous order. Inasmuch as claimant's request emanates from an own motion order, we retain jurisdiction over this matter. David L. Waasdorp, 38 Van Natta 81 (1986).

In response to these contentions, SAIF asserts that claimant was not entitled to temporary disability benefits pursuant to the aforementioned order. Noting that claimant's commission income actually increased during the period in question, SAIF argues that any temporary disability benefits due under the Board's order were more than offset by his earned income. Since no additional compensation resulted from our prior order, SAIF further contends that no attorney fee was due as well. Finally, SAIF submits that claimant and his counsel have been aware of SAIF's position in this matter since September 1985.

Claimant replies that SAIF did not consider his loss of "new business" during this period. Besides, he argues that the entitlement issue has already been addressed by the Board in its prior order. Because SAIF was directed to pay temporary disability benefits and has failed to do so, claimant asserts that penalties and attorney fees are justified for this noncompliance. Even assuming that he was not entitled to temporary disability benefits as a result of the Board's prior order, claimant contends that SAIF would still be required to pay his attorney fee.

We disagree with claimant's contentions. Following our review of this matter, we are persuaded that SAIF complied with the Board's prior order. Consequently, claimant is neither entitled to temporary disability, penalties, nor attorney fees.

We find that claimant's increased income during the relevant time more than offset any temporary compensation attributable to that period. Inasmuch as temporary disability benefits awarded by the Board's July 17, 1985 order were to be reduced by "any time worked," we conclude that claimant was not entitled to temporary disability benefits pursuant to the prior order.

Claimant further argues that SAIF is required to pay the attorney fee even though the entire award of compensation might be offset. In support of his contention, claimant relies on

Weyerhaeuser Company v. Sheldon, 86 Or App 46 (1987). In Sheldon, the court affirmed a Referee and Board order that had directed an employer to pay attorney fees for claimant's attorney's services in obtaining increased permanent disability compensation pursuant to a prior Referee's order, even though the award was entirely offset against a previous overpayment. The court concluded that the Board did not err in applying OAR 438-47-085(2), which provides as follows:

> "An attorney fee which has been approved in accordance with 47-025 or 47-030 to be paid from increased compensation awarded by a Referee, the Board or the Court of Appeals shall not be subject to any set-off based on prior overpayment of compensation to claimant by the employer or its insurance carrier. The employer or carrier shall pay the approved attorney fee to the claimant's attorney."

We consider the present case to be distinguishable. In Sheldon, the relevant Board rule was OAR 438-47-085(2), which specifically restricts its application to attorney fees approved in accordance with OAR 438-47-025 and 438-47-030. These latter rules pertain to situations where a claimant has requested a hearing concerning the extent of permanent or temporary disability and receives an increased award.

OAR 438-47-085(2) has no application to this situation. Rather, the pertinent Board rule is OAR 438-47-070(2), which provides that, in own motion proceedings initiated by claimant, an attorney fee shall be approved payable out of any increased award of compensation. See also Bernie Hinzman, 35 Van Natta 739, 1374 (1983). (Where the request for relief stems from claimant's request for additional compensation and not from an insurer's request to reduce or disallow compensation, the attorney fee is payable out of, and not in addition, to the increased award).

Because the Board's prior order did not result in an increased award of compensation, there was no award from which to apportion claimant's reasonable attorney's fee. See OAR 438-47-070(2). Thus, we conclude that claimant was not entitled to an attorney fee pursuant to the prior order.

Accordingly, based on the foregoing reasoning, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

ROGER L. VOHS, Claimant
Merrill Schneider & Assoc., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-14035
December 31, 1987
Order Dismissing Request for Review and Remanding

Claimant requested Board review of Referee Mulder's order that declined to address claimant's requests for relief until he attended an independent medical examination scheduled by the insurer. Noting that he has agreed to attend the independent medical examination, claimant asks that this matter be remanded to the Hearings Division. The request for remand is granted.

Accordingly, claimant's request for Board review is dismissed. This case is remanded to Referee Mulder for further proceedings consistent this order and the Referee's prior order.

IT IS SO ORDERED.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-12353
November 27, 1987
Order of Abatment

The Board has received claimant's request for abatement and reconsideration of its Order on Review dated November 10, 1987 insofar as the SAIF Corporation was allowed an offset of permanent partial disability paid between the effective date of claimant's permanent total disability award and the date of the Referee's order.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. SAIF is requested to file a response to the motion within ten days. Thereafter, the Board will take this matter under advisement.

IT IS SO ORDERED.

HARRY N. HUNSLEY, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-02203
November 4, 1987
Order of Abatement

The insurer has requested reconsideration of our Order on Review (Remanding) dated October 12, 1987. In order to allow time for claimant to respond and for the Board to consider the request, our Order on Review (Remanding) is abated and withdrawn, effective this date. Claimant is allowed 14 days from the date of this order in which to file a response.

IT IS SO ORDERED

Richard R. Ingalls, Claimant
Pozzi, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 86-03202
December 18, 1987
Order of Abatement

Claimant and the SAIF Corporation have requested reconsideration of our November 20, 1987 interim order that remanded this matter to the Referee with instructions to reconvene a hearing. This action was prompted by the hearing reporter's failure to provide a transcript of the parties' previous hearing.

Contending that a new hearing would be impractical, unfair, and potentially prejudicial to their respective positions, the parties object to our interim order. Instead, they suggest that we take further actions designed to recover the hearing transcript.

In order to allow sufficient time to consider the parties' request, the Board's Interim Order of Remand is stayed and abated. Meanwhile, the Board shall renew its attempts to secure a hearing transcript and will keep the parties advised of any further developments in this matter.

IT IS SO ORDERED.

PETER G. JEBENS, Claimant
Cash Perrine, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-09843
December 23, 1987
Order of Abatement

Claimant has requested reconsideration of the Board's Order on Review dated November 27, 1987. A response has been received from the insurer. In order to allow sufficient time to further consider this matter, the Board withdraws and abates its prior order, effective this date.

IT IS SO ORDERED.

BRIAN W. JOHNSTON, Claimant
Patrick K. Mackin, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-01069
November 5, 1987
Order of Abatement

Claimant requests reconsideration of those portions of the Board's October 8, 1987 Order on Review which: (1) upheld the self-insured employer's denials of his aggravation and medical services claims for his current back condition; and (2) determined that he was not entitled to an award of unscheduled permanent disability. Specifically, claimant contends that his current condition is causally related to his compensable injury and that the Board lacked jurisdiction to consider the extent of his unscheduled permanent disability.

In order to allow sufficient time to consider the motion, the Board's Order on Review is stayed and abated. The employer is requested to file a response to the motion within 14 days. Thereafter, the Board will take the motion under advisement.

EDWARD J. KELLY, Claimant
Galton, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-03841
November 10, 1987
Order of Abatement

Claimant has requested reconsideration of that portion of the Board's Order on Review dated October 13, 1987 that upheld the insurer's denial of authorization for surgery. The request is granted and the Board's prior order is withdrawn for reconsideration and abated. The insurer is allowed 14 days from the date of this order in which to file a reply to claimant's request.

IT IS SO ORDERED.

TED W. PECKHAM, Claimant
Coons & Cole, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-00033
November 6, 1987
Order of Abatement

Claimant has requested reconsideration of the Board's October 8, 1987 Order on Review which affirmed a Referee's finding that claimant was not entitled to temporary disability compensation for the period he was incarcerated. Specifically, claimant contends that he was entitled to temporary disability benefits during his incarceration.

In order to allow sufficient time to consider the motion, the Board's Order on Review is stayed and abated. The insurer is requested to file a response to the motion within 14 days of this order. Thereafter, the Board will take the motion under advisement.

IT IS SO ORDERED.

CHARLES M. POOLE, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-00045
November 13, 1987
Order of Abatement

Claimant has requested reconsideration of the Board's Order on Review dated October 19, 1987. In order to allow sufficient time for the Board to consider the request, the Board's Order on Review is stayed and abated. The self-insured employer is allowed 14 days from the date of this order in which to file a response. Thereafter, the Board will take the request under advisement.

IT IS SO ORDERED.

BOARD RULES

CONTENTS

NOTE

Page numbers in Tables of Contents refer to pages in Van Natta's. The original copies of the new rules are paged independently. References to new rules are best made by using the OAR number.

CERTIFICATE AND ORDER FOR FILING PERMANENT ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

DEC 18 2 53 PM '87

BARB... SECRETARY OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of **PERMANENT** rule(s) adopted on December 18, 1987 (Date)

by the Workers' Compensation Board (Department) (Division)

to become effective January 1, 1988 (Date)

The within matter having come before the Workers' Compensation Board (Department) (Division) after

all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

Notice of Intended Action published in Secretary of State's Bulletin: NO ☐ YES ☒ Date Published: November 15, 1987

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken: (List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

Adopted (New Total Rules): OAR 438-13-005 through 438-13-040, 438-14-005 through 438-14-035, 438-15-001 through 438-15-100

Amended (Existing Rules): OAR 438 Divisions 05, 06, 07, 08, 09, 11 and 12.

Repealed (Total Rules Only): OAR 438 Divisions 10 and 47.

RECEIVED
DEC 18 1987
LEGISLATIVE COUNSEL'S OFFICE

as Administrative Rules of the Workers' Compensation Board (Department) (Division)

DATED this 18th day of December, 19 87

By: [signature] (Authorized Signer)

Title: Chairman Member Member

Statutory Authority ORS 656.307, 656.388, 656.593, 656.726(4)

Chapter(s) 234, 373, 713 and 884, Oregon Laws 19 87

House Bill(s) ____, 19____ Legislature; or Senate Bill(s) ____, 19____ Legislature

Subject Matter: Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, including Expedited Claims, Arbitration of Responsibility among industrial insurers and award or allowance of attorney fees in contested cases.

For Further Information Contact T. Lavere Johnson, Chairman (Rule Coordinator) Phone: 378-3308

BEFORE THE WORKERS' COMPENSATION BOARD

OF THE STATE OF OREGON

In the Matter of the Adoption of Permanent Rules of Practice and Procedure and Award or Allowance of Attorney Fees in Contested Cases under the Workers' Compensation Law, OAR Chapter 438	)	WCB Admin. Order 5-1987
	)	ORDER OF ADOPTION

1. On November 5, 1987 the Workers' Compensation Board ("Board") filed a Notice of Proposed Rulemaking Hearing with the Secretary of State, giving notice of its intent to adopt permanent rules relating to practice and procedure and award or allowance of attorney fees in contested cases under the Workers' Compensation Law. The notice was published in the Oregon Bulletin, Volume 27, No. 10, on November 15, 1987, and was mailed to members of the Workers' Compensation Section of the Oregon State Bar and other persons as their interests appeared. Pursuant to the notice, a public hearing was conducted by Douglas W. Daughtry, Presiding Referee, on December 2, 1987 at Salem, Oregon. The record of the public hearing was left open for the receipt of additional written comments and was closed at 5 p.m. on December 14, 1987.

2. At the hearing, testimony was received from 17 persons as individuals or representatives of groups and organizations. In addition to the oral testimony, written comments were received, in the form of 34 documents from various individuals and organizations. Copies of the transcript of the public hearing and of all written comments received are available for public inspection and copying at the offices of the Board, 480 Church Street, S.E., Salem, Oregon 97310, during normal working hours from 8 a.m. to 5 p.m. Monday through Friday.

3. The Board has thoroughly reviewed and considered all comments pertaining to its proposed rules of practice and procedure and award or allowance of attorney fees in contested cases under the Workers' Compensation Law. Due to the volume of comments received, it is not feasible for the Board to address each comment individually. A summary of the major revisions to the proposed rules in response to comments from the Board's staff and the public follows.

Division 05

Rule 438-05-010. Effective Date; Applicability. The rule was changed to reflect that Division 12 relating to the Board's Own Motion Jurisdiction would apply only to claims actually reopened after January 1, 1988.

Rule 438-05-035. Board Policy; Liberal Construction. The rule was changed to delete references to evidence and financial

resources of parties. As adopted, the rule provides that relative financial hardships be considered with respect to requests for postponements and continuances of hearings.

Rule 438-05-046. Filing and Service of Documents. The previous requirement that proof of mailing of jurisdictional documents was limited to a certified or registered mail receipt was changed in response to Weyerhaueser Company v. Miller, 88 Or App 286 (1987). As changed, the rule provides for rebuttable presumptions to prove mailing dates.

Division 06

Rules 438-06-031 and 438-06-036. Specification of Issues and Response. The rules were changed to freely permit amendment of issues and responses up to and including the time of the hearing.

Rule 438-06-045. Motions and Argument. The rule was changed to allow oral motions.

Rule 438-06-081 and 438-06-091. Postponements and Continuances. Numerous commentators suggested that the criteria for postponements and continuances of hearings be broadened to allow greater latitude in postponing and continuing hearings. After considering all comments, the Board has adopted the rules as proposed, except that the Board retained the previous criterion that a hearing may be continued for any reason that would justify postponement.

Division 07

Rule 438-07-005. Medical and Vocational and other Documentary Evidence. In response to comments, the Board has deleted the proposed requirement that all medical and vocational expert testimony be by deposition or interrogatory unless otherwise permitted by the referee. The Board continues to encourage the use of depositions to present expert testimony.

Rule 438-07-015. Exchange and submission of Exhibits. In response to nearly unanimous objection to the proposed requirement of indexing documents in the first exchange, the Board has changed the rule to delete the requirement.

Rule 438-07-016. Disclosure of Expert Witnesses. After considering numerous comments in favor of and opposed to the proposed rule, the Board has adopted the rule with minor changes. As adopted, the rule provides that each party disclose to all others the identity of each expert the party will call to testify at the hearing. The disclosure must be made no later than the time the party is required to furnish its exhibit index. The sanction for failure to comply with the rule is possible exclusion of expert testimony.

Rule 438-07-017. Impeachment Evidence. After considering numerous comments in favor of and opposed to the proposed rule, the Board has adopted the rule in substance. The rule was rewritten to make it clear that all medical and vocational documents must be disclosed if they were created on or after the date of the injury or exposure and are relevant to the claim. Such documents may still be offered for impeachment purposes.

Rule 438-07-018. Exchange of Exhibits. The rule was rewritten to provide that documents intended to be offered as exhibits at a hearing be indexed and exchanged between the parties prior to the hearing. The first submission remains the responsibility of the insurer or self-insured employer. The current time periods for exchanging exhibits were retained. Under this rule, exhibits are to be submitted to the referee before the hearing, which includes at the hearing.

Division 09

Rule 438-09-010. Disputed Claim Settlements. Section (3)(a) of the rule was changed to make it clear that a disputed claim settlement of a backup denial must contain an allegation that the original acceptance was procured by fraud, misrepresentation or other illegal activity.

Rule 438-09-015. Notice of Settlement. The rule was changed to provide that the referee's oral order is sufficient authority for payment of settlement proceeds, if the parties so agree.

Division 11

Rule 438-11-020. Briefs and other Documents. Numerous commentators suggested that 14 days was insufficient time to prepare a brief on Board review. After considering all comments, the Board concludes that the time for briefing must be shortened in order to enable the Board to comply with the statutory requirement that review be completed within 90 days of receipt of a request for review. Under the proposed schedule, the Board would have only 20 days to review the case. If the comments were adopted, the Board would have less than one week to review the case. The Board has adopted the rule as proposed.

Division 12

The Division was totally rewritten to delete any requirement that an own motion insurer issue an acceptance or denial of an own motion claim. The insurer is required to process the claim and recommend to the Board whether the claim be reopened or denied. Reopenings and denials will be by Board Order. Closure of reopened claims will be accomplished by insurers with a provision for Board review of contested closures. The Division was further revised to compliment rules proposed for administration of the Reopened Claims Reserve.

Division 13

Rule 438-13-025. Notice of Hearing Date. The rule was revised to delete section (2) relating to informal dispute resolution. The Board accepted the comments to the effect that the proposed procedure could not be accomplished within the time allowed before the hearing. A requirement that the referee determine whether the dispute could be resolved informally before beginning the hearing was added to rule 438-13-030.

Division 14

Rule 438-14-035 was added to establish the costs of arbitration proceedings to be assessed by Compliance.

General Considerations. Numerous commentators representing the defense bar urged that the Board either not regulate or minimally regulate defense attorney fees. After thorough consideration of all comments, the Board concludes that the 1987 amendment to ORS 656.388(1) (1987 Or Laws, Ch. 884, sec. 35) requires Board regulation of all fees charged by attorneys rendering services in connection with claims under ORS Chapter 656. The Board further concludes that, to the extent possible, regulation must be consistent as applied to both claimant and defense attorneys.

Rule 438-15-010. General Principles. Several commentators suggested that the factors set forth in section (5) do not apply to defense attorneys. The rule requires that all of the factors be considered. In considering the factors, the entity determining the amount of a reasonable attorney fee should consider how each factor applies and the weight of the factor in the particular case.

Rule 438-15-020. Attorney Fees for Attorneys Representing Insurers and Self-Insured Employers. Many commentators expressed concern that the proposed rules would limit a defense attorney's ability to bill for services involving consultation where no litigation was involved. The Board changed the proposed rule to allow a defense attorney to bill a client for certain prelitigation services without the previously proposed limitation that all legal services be completed. The Board concluded that it would be able to monitor such charges by means of the reporting requirement of Rule 438-15-100.

Rule 438-15-025. Maximum Attorney Fees. The Board has accepted the comments that it is impractical to set a maximum amount on fees paid by insurers. In keeping with its conclusion that regulation be consistent as applied to both claimant and defense attorneys, the rule has been changed to delete the maximum fees paid by insurers to both claimant and defense attorneys. In all cases, such fees shall be reasonable. In setting the maximum amounts of fees to be paid out of an injured worker's compensation, the Board considered all comments in light of the purpose of the Workers' Compensation Law. A maximum fee out of increased temporary disability compensation was set at $1,050 for services at a hearing. A maximum fee of $2,800 for services at a hearing in obtaining an increase in permanent partial disability compensation was adopted. The maximum fee for obtaining an increase in temporary or permanent partial disability compensation in a Board review proceeding was set at $3,800. The Board recognizes that a permanent total disability award is a much greater benefit to an injured worker than an award of permanent partial disability and usually requires greater effort on the part of the worker's attorney. The maximum fee for services at a hearing in obtaining an award of permanent total disability was set at $4,600. The Board reached this figure by applying several tests to the previous maximum fee, including the increase in the adjusted consumer price indexes, the percentage increase in the average weekly wage and the percentage increase in the average present value reserve of a permanent total disability award since the maximum fee was last changed in 1974. The maximum fee for obtaining an award of

permanent total disability in a Board review was set at $6,000, in recognition of the efforts required both at hearing and on review to obtain such an award. The Board retained a provision that in truly extraordinary cases the referee or Board has discretion to award a fee in excess of the maximum, if the worker agrees to such a fee.

Rule 438-15-080. Attorney Fees in Own Motion Cases. The rule was changed to delete reference to insurer paid fees in denied claim cases pursuant to the revision of Division 12 eliminating such situations.

Rule 438-15-090. Attorney Fees in Arbitration of Responsibility Cases. The Board concluded that the proposed rule was potentially confusing. The rule was rewritten to reflect the statutory language in ORS 656.307.

Rule 438-15-100. Reporting Requirement for Insurers and Self-Insured Employers. Several commentators suggested that requiring a report for calendar year 1987 was inappropriate. The rule requires reporting only if data are available. The Board concludes that most insurers already maintain data on outside loss adjustment expense. The Board is not requiring retroactive record keeping.

4. Under the authority granted by ORS 656.726(4), the Board finds:

a. That all applicable rulemaking procedures have been followed, and

b. That the rules being adopted are reasonable, necessary and proper.

In accordance with its notice of proposed rulemaking, it is hereby ORDERED

That Rules 438-05-005 through 438-15-100 as set forth on Exhibit "A", attached hereto and hereby incorporated into and made a part of this order, are hereby adopted as permanent rules of the Workers' Compensation Board, effective January 1, 1988.

DATED this 18 day of December, 1987.

WORKERS' COMPENSATION BOARD

T. Lavere Johnson, Chairman

Evelyn S. Ferris, Member

Lynn-Marie Crider, Member

RULES OF PRACTICE AND PROCEDURES FOR CONTESTED CASES

UNDER THE WORKERS' COMPENSATION LAW

OREGON ADMINISTRATIVE RULES CHAPTER 438

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UNDER THE WORKERS' COMPENSATION LAW

DIVISION 05

ADOPTION; DEFINITIONS; CONSTRUCTION; NOTICES REQUIRED

438-05-005 STATUTORY AUTHORITY. These rules are adopted under the Board's general rulemaking authority of ORS 656.726(4) and the specific mandates for rulemaking contained in 1987 Oregon Laws, Chapters 234, 373, 713 and 884 to provide rules of practice and procedure for hearing and review proceedings under ORS 656.001 to 656.990, for exercising its continuing authority under ORS 656.278 and providing for the payment of attorney fees in cases under the Workers' Compensation Law pursuant to ORS 656.388.

438-05-010 EFFECTIVE DATE; APPLICABILITY. These rules are effective January 1, 1988 and shall apply to all cases pending before the Hearings Division under the provisions of ORS 656.283, 656.291, 656.307 and 656.740 and before the Board under the provisions of ORS 656.295, 656.307 and 656.576 to 656.595 on and after that date. With respect to matters before the Board on its own motion under ORS 656.278, these rules shall apply only to cases in which claim reopening is ordered by the Board on or after January 1, 1988.

438-05-015 ADOPTION OF ATTORNEY GENERAL MODEL RULES. The following Attorney General Model and Uniform Rules are hereby adopted by reference: OAR 137-01-005 through 137-01-085, 137-03-055 and 137-04-010.

438-05-030 SAFETY RULES REFERENCE. Rules pertaining to the Oregon Safe Employment Act, ORS 654, may be found at OAR 438, division 85.

438-05-035 BOARD POLICY; LIBERAL CONSTRUCTION. It is the policy of the Board to expedite claim adjudication and amicably dispose of controversies. These rules shall be liberally construed in favor of the injured worker to carry out the remedial and beneficent purposes of the Workers' Compensation Law. The overriding principle is substantial justice. With respect to postponement or continuance of hearings, substantial justice requires consideration of the relative financial hardship of the parties. The unrepresented injured worker shall not be held strictly accountable for failure to comply with these rules. Any individual who undertakes to represent a party in proceedings under these rules shall be required to comply with these rules.

438-05-037 PENALTY FOR FAILURE TO COMPLY WITH RULES. If failure to comply with these rules by an insurer or self-insured employer results in delay in compensation ultimately ordered paid to a claimant by a referee, penalties and attorney fees may be assessed on such compensation for unreasonable delay under the provisions of ORS 656.262(10).

438-05-040 GENERAL DEFINITIONS.

(1) "Aggravation" means a worsening of conditions resulting from the original injury after the last award or arrangement of compensation.

(2) "Aggravation rights" means the time periods specified in ORS 656.273 during which an injured worker is entitled to additional compensation for worsened conditions as a matter of right.

(3) "Board" means the Workers' Compensation Board.

(4) "Claimant" means an injured worker or any other person entitled to initiate or continue a claim for compensation.

(5) "Compliance" means the Compliance Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(6) "Director" means the Director of the Department of Insurance and Finance or his designee.

(7) "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(8) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(9) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state.

(10) "Party" means a claimant, an employer, including a noncomplying employer, the SAIF Corporation as processing agent in cases under ORS 656.054, and an insurer.

(11) "Self-insured employer" means an employer or group of employers certified under ORS 656.430 as meeting the qualifications set out in ORS 656.407.

438-05-046 FILING AND SERVICE OF DOCUMENTS; CORRESPONDENCE.

(1) Filing.

(a) "Filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing.

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

(c) Except for the documents specified in section (b) of this rule, filing of any other thing required to be filed within a prescribed time may be accomplished by mailing 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. If the thing is not received within the prescribed time and no certificate of mailing is furnished, it shall be presumed that the filing was untimely unless the filing party establishes that the filing was timely.

(2) Service.

(a) A true copy of any thing delivered for filing under these rules shall be simultaneously served personally or by mailing by first-class mail, postage prepaid, through the United States Postal Service, to each other party, or to their attorneys. Service by mail is complete upon mailing.

(b) Any thing delivered for filing under these rules shall include or have attached thereto either an acknowledgment of service by the person served or proof of service in the form of a certificate executed by the person who made service showing personal delivery or deposit in the mails together with the names and addresses of the persons served.

(3) Correspondence. All correspondence to the Board shall be captioned with the name of the claimant, the WCB Case number and the insurer or self-insured employer claim number. Correspondence to the Hearings Division shall also be captioned with the date of the hearing and name of the assigned referee, if any.

438-05-050 NOTICE OF CLAIM ACCEPTANCE AND HEARING RIGHTS.

Every notice of acceptance shall state whether the claim is considered disabling or nondisabling. If the claim is considered nondisabling, the notice shall notify the claimant of hearing and aggravation rights and of the Expedited Claim Service in substantially the following language:

"Your claim is called a 'nondisabling injury' since you returned to work within three calendar days after leaving work as a result of your injury and you have no permanent disability as a result of this injury.

"You should call your employer's insurer if you feel that a mistake was made in your claim being accepted as nondisabling.

"If you then object to the insurer's decision classifying your injury as nondisabling, you have the right to request a reclassification by writing to the Workers' Compensation Division. This request must be filed with the Division. If you remain dissatisfied, you may request a hearing from the Workers' Compensation Board. If your claim qualifies, you may receive an expedited hearing within 30 days.

"You may be entitled to additional benefits in the future, if your condition from the injury worsens. This is called AGGRAVATION. To obtain aggravation benefits, you should apply in writing to the employer or insurer which first handled your claim.

"If you are unable to locate the employer or the employer's insurer, you may submit your claim directly to the Workers' Compensation Division.

"The claim for aggravation must be filed within five years after the date of injury."

438-05-055 NOTICE OF CLAIM DENIAL AND HEARING RIGHTS.

In addition to the requirements of ORS 656.262, the notice of denial shall specify the factual and legal reasons for denial, and shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS DENIAL IS NOT RIGHT, WITHIN 60 DAYS AFTER THE DATE OF THIS LETTER YOU MUST FILE A LETTER WITH THE WORKERS' COMPENSATION BOARD, 480 CHURCH STREET, S.E., SALEM OREGON 97310. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE. IF YOUR CLAIM QUALIFIES, YOU MAY RECEIVE AN EXPEDITED HEARING WITHIN 30 DAYS. YOUR REQUEST CANNOT, BY LAW, AFFECT YOUR EMPLOYMENT. IF YOU DO NOT FILE A REQUEST WITHIN 60 DAYS, YOU WILL LOSE ANY RIGHT YOU MAY HAVE TO COMPENSATION UNLESS YOU CAN SHOW GOOD CAUSE FOR DELAY BEYOND 60 DAYS. AFTER 180 DAYS ALL YOUR RIGHTS WILL BE LOST. YOU MAY BE REPRESENTED BY AN ATTORNEY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES."

438-05-060 NOTICE OF PARTIAL DENIAL AND HEARING RIGHTS. Every notice of partial denial shall set forth with particularity the injury, condition , benefit or service for which responsibility is denied and the factual and legal reasons therefor. The notice shall be in the form specified by 438-05-055.

438-05-065 MANNER OF GIVING NOTICE. Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons.

438-05-070 REQUEST FOR HEARING. Proceedings before the Hearings Division are begun by filing a request for hearing meeting the requirements of ORS 656.283. The request for hearing should be on a form prescribed by the Board. In addition to the information required by ORS 656.283(3), the person requesting a hearing should include the person's full name, the name of the injured worker if different from that of the person requesting the hearing, the injured worker's social security account number, the date of the injury or exposure, the name of the employer and its insurer, if any, and the claim number. A copy of the request should be mailed to the insurer or self-insured employer.

438-05-075 DUTY TO FORWARD MISDIRECTED REQUEST. If a claimant sends a request for hearing to the employer or insurer, the employer or insurer shall promptly forward the request to the Board.

DIVISION 06

PROCEDURES PRIOR TO HEARING IN ORDINARY CASES

438-06-020 ACKNOWLEDGMENT; NOTICE OF CONFERENCE AND HEARING IN ORDINARY HEARING PROCESS.

The Hearings Division shall mail an acknowledgment, notice of date of informal dispute resolution conference and notice of hearing date. The conference shall be scheduled for a date that is within 30 days of the request for hearing. The conference may be scheduled as a telephone conference. The hearing shall be scheduled for a date that is within 90 days of the request for hearing and not less than 30 days after mailing of the notice.

438-06-031 SPECIFICATION OF ISSUES. Not later than 15 days after the first disclosure of documents under 438-07-015, the party who requested the hearing shall, on a form prescribed by the Board, file with the Board and simultaneously mail copies to all other parties a specific listing of all issues to be raised at the hearing and all relief requested. Amendments shall be freely allowed up to the date of the hearing. If, during the hearing, the evidence supports an issue or issues not previously raised, the referee may allow the issue(s) to be raised during the hearing. The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice.

438-06-036 RESPONSE. Not later than 15 days after receiving the listing of issues and other information required by 438-06-031, a party defending against a request for hearing shall, on a form prescribed by the Board, file and simultaneously mail copies to all other parties a response specifying the respondent's position on the issues raised and relief requested and any additional issues raised and relief requested by the respondent. Amendments shall be freely allowed up to the date of the hearing. If, during the hearing, the evidence supports an issue or issues not previously raised, the referee may allow the issue(s) to be raised during the hearing. The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice.

438-06-037 WAIVER OF NOTICE. A party may waive objection to lack of notice, or a defect in the form of notice, of any issue raised at a hearing.

438-06-040 PREMATURE REQUESTS TO ADJUDICATE DISABILITY. Except as provided in 438-08-020 issues of permanent disability shall not be adjudicated unless the claim has been once considered by Evaluation or the insurer under ORS 656.268.

438-06-045 MOTIONS, ARGUMENTS. Unless otherwise agreed among the parties and the referee, pre or post hearing motions shall be filed in writing and copies shall be served on all parties. Ten days after filing shall be allowed for written response to a motion.

438-06-050 PRELIMINARY RULINGS. The presiding referee or his or her delegate shall rule on all preliminary matters.

438-06-055 DEPOSITIONS. Depositions of medical or vocational experts are permitted by agreement of the parties, or by approval of a referee, subject to the provisions of ORS 656.285. Discovery depositions of claimants and other lay witnesses are not permitted over objection unless the presiding referee or his or her delegate finds that extraordinary circumstances justify the deposition.

438-06-061 INFORMAL DISPUTE RESOLUTION.

(1) If the party that requested the hearing is the claimant and is represented by an attorney, the claimant's attorney shall notify the presiding referee, or his or her delegate, on a form prescribed by the Board not less than seven (7) calendar days prior to the conference scheduled under 438-06-020 whether or not settlement has been achieved. If settlement has not been achieved, the attorney's notice shall state whether he or she has conferred with the other party(ies) or its (their) representative(s). The conference shall be held as scheduled unless the claimant's attorney has contacted the other party(ies) or its (their) representative(s) and states on the notice that settlement cannot be achieved.

(2) In all other cases, the conference shall be held as scheduled.

(3) The conference shall not be postponed for any reason.

(4) A party may participate in the conference with or without an attorney, and may be represented by an individual who is not an attorney, subject to limitations of ORS 656.283(10).

438-06-065 CONSOLIDATION AND JOINDER.

(1) Any claim asserted by a claimant against any insurer or self-insured employer shall be consolidated with the pending case when the referee finds consolidation is necessary for full determination of the issues.

(2) Other insurers or employers shall be joined as parties in the pending case if the referee finds on motion of an insurer or self-insured employer that joinder is necessary to determine an issue of responsibility, and if the insurer or self-insured employer requesting joinder has acted, immediately after it first knew or should have known there was a question of responsibility, to involve the other insurer(s) or employer(s) in accordance with OAR Chapter 436, Division 60. Such party shall receive at least ten (10) days notice of hearing on the merits.

438-06-071 FAILURE OF PARTY TO APPEAR. Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under 438-06-081.

438-06-075 EXPEDITED REMEDY FOR FAILURE TO PAY TEMPORARY DISABILITY.

(1) If it is alleged that the insurer has terminated temporary disability compensation without: the attending physician's approval of the worker's return to his regular employment; or the injured worker's actual return to work; or the issuance of a determination order or notice of closure; or authorization of the Board or Evaluation or Compliance, the claimant may file with the Hearings Division with copies to the insurer, a motion supported by affidavit asserting the failure to receive such compensation. The motion shall include any claim for penalties and attorney fees. The affidavit shall state that none of the events justifying termination of compensation has occurred and shall be prima facie evidence of the matter contained therein.

(2) (a) If the Hearings Division determines that the amount in controversy is less than $1,000, the case shall be referred to the Expedited Claims Service under the provisions of Division 13 of these rules.

(b) If the matter cannot be resolved by referral to the Expedited Claims Service, the Hearings Division shall immediately upon receipt of the motion and affidavit issue an Order requiring the insurer to show cause within fifteen (15) days why said compensation has not been provided to the claimant. The show cause order shall contain notice of the date, time and place of the show cause hearing.

(3) Immediately upon the conclusion of the hearing or expiration of the fifteen (15) days, the referee shall enter an Order denying or granting temporary disability compensation and awarding penalties and attorney fees when appropriate.

438-06-081 POSTPONEMENT OF HEARINGS. A scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. "Extraordinary circumstances" shall not include:

(1) Failure of the insurer to refer or delay in referring the case or any pertinent information to its representative;

(2) Unavailability of a party, witness or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments, vacation, or unwillingness to appear;

(3) An attorney's, party's, representative's or witness' conflict with administrative or judicial proceedings scheduled more than three days after mailing of the notice of hearing, absent a direct order of a court refusing to reschedule a judicial proceeding or compelling appearance thereat;

(4) Incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence.

438-06-091 CONTINUANCES. The parties shall be prepared to present all of their evidence at the scheduled hearing. 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.

438-06-095 CHANGE OF REFEREE.

(1) A referee may withdraw from a case whenever he or she considers himself or herself disqualified.

(2) 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.

(3) 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.

(4) If the presiding referee does not disqualify the referee, the presiding referee shall so rule on the record, stating the grounds for his ruling, and the case shall proceed with the referee.

438-06-100 REPRESENTATION BY COUNSEL. Except as permitted by ORS 656.283 and 656.291, corporations and state agencies must be represented by members of the Oregon State Bar. The Board encourages injured workers also to be represented by counsel in formal hearings.

438-06-105 DEFERRED HEARINGS. A hearing will not be held on an issue of unscheduled permanent disability when the claimant is entitled to temporary disability compensation under the claim in which the hearing was requested, except where there is an interruption of compensation or upon a showing of good cause.

DIVISION 07

EVIDENCE - HEARINGS

438-07-005 MEDICAL AND VOCATIONAL AND OTHER DOCUMENTARY EVIDENCE.

(1) Statutory references: medical reports as evidence, ORS 656.310(2); vocational reports, ORS 656.287.

(2) To avoid unnecessary delay and expense medical evidence should be presented in the form of written reports and should include:

(a) History of the injury or disease;

(b) Pertinent medical history;

(c) Present complaints;

(d) All sources of history and complaints;

(e) Date of examination;

(f) Findings on examination;

(g) Impairment of physical or mental function including loss of reserve capacity;

(h) Restrictions of activities, such as lifting, bending, twisting, sitting, standing and repetitive use;

(i) Cause of the impairment and opinion whether the impairment is all or in part work related;

(j) Medical treatment indicated;

(k) Likelihood of permanent impairment and opinion whether the condition is likely to change; and

(l) The reason for the opinion.

(3) The insurer may subpoena the claimant's attending or consulting physician(s) or vocational expert for cross-examination. Medical, surgical, hospital and vocational reports offered by the insurer will also be accepted as prima facie evidence provided the insurer agrees to produce the medical or vocational expert for cross-examination upon request of the claimant. The reports of any medical or vocational expert who has refused to make herself or himself available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received. The cost of cross-examination of any medical or vocational expert under this section shall be paid by the insurer.

(4) To avoid unnecessary cost and delay, the Board encourages the use of written interrogatories or depositions to secure medical or vocational expert testimony.

(5) The referee may appoint a medical or vocational expert to examine the claimant and to file a report with the referee. The parties may also agree in advance to be bound by such expert's findings. The cost of examination and reports under this rule shall be paid by the insurer.

438-07-010 COMPETENCY OF VOCATIONAL EXPERTS. Vocational reports and testimony are admissible as expert opinion evidence if the referee finds the author or witness to be qualified as an expert or if the parties stipulate to the author's or witness' qualifications as an expert in vocational assistance matters.

438-07-015 ENTITLEMENT TO CLAIMS INFORMATION - FULL DISCLOSURE REQUIRED.

(1) References to the insurer and the claimant include their representatives.

(2) Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand accompanied by an attorney retention agreement or medical information release, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant and other insurers, without cost, originals or legible copies of all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim(s). Upon specific demand by the claimant, payroll records shall be obtained by the insurer from the employer and provided in the same manner as other documents. Failure to comply with this section shall be considered delay or refusal under ORS 656.262(10) and may be grounds for exclusion of documents upon motion of the adverse party.

(3) Upon written demand by the insurer(s), the claimant shall within fifteen (15) days of the mailing of said demand, furnish to the insurer(s), without cost, copies of all medical and vocational reports and other documents pertaining to the claim which the insurer(s) would not reasonably be expected to receive through claims processing. Failure to comply with this section may be considered grounds for continuance of the hearing or exclusion of documents upon motion of the adverse party.

(4) Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents. A party's failure to comply with this section may result in the same sanctions as provided in sections (2) and (3) above.

(5) Reports of vocational assistance providers and consultants shall be grouped and indexed separately from all other documents.

(6) At the hearing the referee may in his or her discretion allow admission of additional medical reports or other documentary evidence, or expert testimony, not disclosed as required by these rules. In exercising this discretion, the referee shall determine if material prejudice and surprise has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to disclose earlier. In all cases, the party with the burden of proof shall have the right of last presentation of evidence.

438-07-016 DISCLOSURE OF EXPERT WITNESSES REQUIRED. Within the times provided for the initial exchanges of exhibits and indexes under 438-07-018 each party shall disclose to all other parties the identity of each expert witness the party will call to testify at the hearing. Failure to comply with this rule may be a ground for exclusion of expert testimony upon motion.

438-07-017 IMPEACHMENT EVIDENCE. All medical or vocational material pertaining to, and created on or after the date of injury or exposure giving rise to, the claim(s) in issue at the hearing shall be disclosed under 438-07-015. Other

documents reasonably believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Documents so offered shall not be considered by the referee as substantive evidence. Upon request, all such documents shall be disclosed prior to the close of the hearing, whether or not offered, at which time the other party may offer the documents as substantive evidence.

438-07-018 EXCHANGE OF EXHIBITS.

(1) Not later than twenty (20) days before the hearing, the insurer or self-insured employer shall provide the claimant and other insurer or self-insured employer legible copies of all documents that are relevant and material to the matters in dispute in the hearing, together with an index. The documents shall be arranged in chronological order and numbered, in Arabic numerals, in the lower right corner of each page, begining with the document of earliest date. The numbers shall be preceded by the designation "Ex," and pagination of multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document two shall be designated "Ex 2-2." The index shall include the document numbers, description of each document, author, number of pages and date of the document.

(2) Not less than ten (10) days before the hearing, or within seven (7) days of receipt of the insurer document index and documents, whichever is later, the claimant shall provide the insurer(s) or self-insured employer(s) legible copies of any additional documents that are relevant and material to the matters in dispute in the hearing. The additional documents shall be marked and accompanied by a supplemental document index, prepared in the same manner as the insurer documents and indexed and numbered to coincide in chronological order with the insurer's documents. Letter subdesignations shall be used to insure chronological numbering. For example, a document which is chronologically between documents six and seven of the insurer documents shall be designated "Ex 6A."

(3) Before the hearing, each party shall submit legible copies of its documents and indexes to the referee. Any document(s) not previously exchanged under sections (1) and (2) of this rule shall be numbered and indexed in accordance with those sections.

438-07-019 TESTIMONY AT HEARINGS.

All testimony at the hearing shall be upon oath or affirmation administered by the referee.

438-07-020 WITNESS FEES. Witness fees and mileage in workers' compensation cases are payable as in civil actions.

438-07-025 RECONSIDERATION.

(1) The referee may reopen the record and reconsider his or her decision before a request for review is filed or, if none is filed, before the time for requesting review expires. Reconsideration may be upon the referee's own motion or upon a motion by a party showing error, omission, misconstruction of an applicable statute or the discovery of new material evidence.

(2) A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state;

(a) The nature of the new evidence; and

(b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing.

DIVISION 08

AGGRAVATION CASES

438-08-005 DENIAL - ACCEPTANCE; DETERMINATION OF DISABILITY.

Aggravation claims directed to the Board shall be forwarded forthwith to the insurer and considered filed under ORS 656.273(4) on the date filed with the Board. An untimely aggravation claim shall be considered a claim for medical services under ORS 656.245.

438-08-010 MEDICAL VERIFICATION OF AGGRAVATION.

Written notice by or on behalf of claimant, or a physician's report indicating a need for further treatment or additional compensation (ORS 656.273(3), satisfies the statute of limitations (ORS 656.273(4); however, the first installment of compensation due under ORS 656.262(4) need not be paid until the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition (ORS 656.273(6).

438-08-015 AGGRAVATION CLAIM ACCEPTANCE OR REJECTION.

The insurer must either accept or reject an aggravation claim within 60 days after notice or knowledge of the claim. A denial shall be in the form specified in 438-05-055.

438-08-020 REFEREE DETERMINATION OF AGGRAVATION DISABILITY.

In denied aggravation claims when it appears that the claimant's condition is medically stationary, and that the aggravation claim is compensable, the referee may determine, or the parties may agree on, the extent of temporary and permanent disability in lieu of referral to Evaluation.

DIVISION 09

COMPROMISE AND SETTLEMENT

438-09-005 SETTLEMENTS

(1) Disputes regarding permanent disability may be resolved by the parties after Evaluation or the insurer has once determined the claim under ORS 656.268.

(2) Disputes regarding claims that are not required by law to be considered or initially closed by Evaluation may be resolved by agreement of the parties without referral to Evaluation.

(3) All settlements that provide for an award of compensation for permanent disability shall recite the body

part(s) involved in the award(s) and shall recite all awards in both degrees of unscheduled or scheduled disability and percent of lost earning capacity or loss of use or function of a scheduled body part. Unless the intent of the parties can be established on the face of the document, any irregularity between the stated degrees and percentages shall be resolved against the drafter of the settlement documents.

438-09-010 DISPUTED CLAIM SETTLEMENTS.

(1) Any document submitted for approval by the Board or the Hearings Division as a settlement of a denied and disputed claim shall be in the form specified by this rule.

(2) A disputed claim settlement shall recite, at a minimum:

(a) The date and nature of the claim;

(b) That the claim has been denied and the date of the denial;

(c) That a bona fide dispute as to the compensability of the claim exists and that the parties have agreed to compromise and settle the denied and disputed claim under the provisions of ORS 656.289(4);

(d) The factual allegations and legal positions in support of the claim;

(e) The factual allegations and legal positions in support of the denial of the claim;

(f) That each of the parties has substantial evidence to support the factual allegations of that party; and,

(g) The terms of the settlement.

(3) If a claim was previously accepted and later denied, in whole or in part, the disputed claim settlement shall further recite:

(a) If the accepted claim is later denied entirely, an allegation that the original acceptance of the claim was procured by means of fraud, misrepresentation or other illegal activity; or

(b) If the denial is a denial of aggravation, current need for medical services or a partial denial of a medical condition on the ground that the condition is not related to the accepted injury, that the claimant retains all rights that may later arise under ORS 656.245, 656.273, 656.278 and 656.340, insofar as these rights may be related to the original accepted claim.

438-09-015 NOTICE OF SETTLEMENT; SUBMISSION OF DOCUMENTS.

(1) The party that requested the hearing shall promptly notify the presiding referee, or his or her delegate, when a case is settled in whole or in part.

(2) The presiding referee, or his or her delegate, may require written notice of settlement as a condition of cancellation of a scheduled hearing.

(3) With the consent of the assigned referee, the parties may enter a settlement on the oral record at the time and place scheduled for the hearing. With the exception of a disputed claim settlement, the referee may enter an order reciting and approving the settlement in such cases, without the submission of documents by the parties. With the consent of the parties, the official oral record, including the referee's approval, which is subject to transcription if necessary, is sufficient authority for the payment of settlement amounts in advance of the formal written order.

(4) In all cases settled by written stipulation of the parties, the original and six (6) legible copies of the settlement document shall be submitted to the referee or the Board for approval. The original document shall be retained in the Board's file and necessary copies shall be conformed and distributed to the parties and Compliance.

DIVISION 11

BOARD REVIEW; THIRD PARTY ORDERS

438-11-005 REQUEST FOR BOARD REVIEW.

(1) The time for and manner of filing a request for Board review of a Referee's order are set forth in ORS 656.289 and 656.295.

(2) Copies of a request for Board review of a referee's order shall be simultaneously mailed to all parties who appeared at the hearing and to their attorneys, if represented by an attorney.

(3) The request should recite the name of the claimant, the WCB case number, the identity of the party requesting review and should contain a brief statement of the reason review is requested.

438-11-010 APPLICABILITY.

These rules apply to all cases in which a party or parties request Board review of an order of a Referee pursuant to ORS 656.289, 656.291, 656.295 and 656.307 and to cases in which a party requests a decision of the Board under the third party law, ORS 656.576 to 656.595. These rules do not apply to proceedings before the Board on its own motion pursuant to ORS 656.278 and proceedings before the Board after remand from an appellate court.

438-11-015 SCOPE OF BOARD REVIEW.

(1) Except as provided by ORS 656.307 for review of arbitration decisions in responsibility disputes between insurers and in cases under the third party law, review by the Board is de novo upon the entire record. The Board may remand a matter to the Hearings Division to take additional evidence, report findings to the Board or to enter an Opinion and Order on remand.

(2) The Board will not ordinarily entertain oral argument. All issues and arguments should be reduced to writing and filed pursuant to 438-11-020. The case will be reviewed in the ordinary course of business without prior notice to the parties of the date or time of review.

438-11-020 BRIEFS AND OTHER DOCUMENTS.

(1) Filing of briefs is not jurisdictional; however, the Board views briefs as a significant aid to the review process. Briefs submitted for consideration by the Board shall comply with this section.

(2) The party requesting Board review shall file its appellant's brief to the Board within 14 days after the date of mailing of the transcript of record to the parties. Respondent(s) shall file its (their) brief(s) within 14 days after the date of mailing of the appellant's brief. Any party who has filed a cross-request for review shall include its cross-appellant's opening brief as a part of its respondent's brief. An appellant may file a reply and/or cross-respondent's brief within seven (7) days after the date of mailing of the respondent's and/or cross-appellant's brief. A cross-appellant may file a cross-reply brief within seven (7) days of the mailing date of a cross-respondent's brief. Unless otherwise authorized by the Board, no other briefs will be considered.

(3) Extensions of time for filing of briefs will be allowed only on written request filed no later than the date the brief is due. A statement whether opposing counsel (or a party if the party is not represented by counsel) objects to, concurs in or has no comment regarding the extension of time requested shall be furnished in all cases. Briefing extensions will not be allowed unless the Board finds that extraordinary circumstances beyond the control of the party requesting the extension justify the extension.

438-11-025 MOTIONS THAT TOLL TIME. Unless otherwise ordered by the Board, the filing of a motion to dismiss a request or cross-request for review or to remand a case to the Hearings Division tolls the time for the next event in the review process.

438-11-030 MOTION FOR WAIVER OF RULES. Except as otherwise prohibited by law, the Board may waive any provision of OAR 438-11 upon motion of a party. A motion for waiver of rules shall include a statement of the facts and circumstances relied upon and shall be simultaneously served upon all other parties or their attorneys. The motion may be allowed if the Board finds that extraordinary circumstances beyond the control of the party requesting waiver of a rule or rules justify such an action.

438-11-035 REVIEW; BOARD ORDER; RECONSIDERATION.

(1) The Board order on review shall set forth the parties, the issues, the Board's decision and shall advise all parties of appeal rights.

(2) A request for reconsideration of a Board order shall include a concise statement of the reason(s) reconsideration is requested. An order on reconsideration shall state whether or not the original order is withdrawn for reconsideration.

438-11-045 THIRD PARTY ORDERS.

(1) Any party requesting the Board's resolution of a controversy arising under the third party law, ORS 656.576 to 656.595, shall petition the Board for relief. The party requesting relief is the petitioner and all other parties are respondents.

(2) The petition shall clearly identify the party seeking relief, shall clearly state the relevant facts and the nature of the dispute and shall specify the relief sought. All relevant evidence shall be attached to the petition. Testimonial evidence shall be by deposition, affidavit or written interrogatories. True copies of the petition and all attachments shall be served on all other parties to the dispute.

(3) The Board shall acknowledge receipt of the petition to all named parties. The respondent(s) shall be allowed 14 days to file evidence and argument in response to the petition. The petitioner shall be allowed seven (7) days to file a reply argument. The time for filing may be extended by the Board upon motion of a party. The Board will issue its order within a reasonable time after all argument and evidence has been filed.

(4) Settlement documents in civil actions under ORS 656.576 to 656.595 shall not be submitted to the Board unless there is a dispute requiring resolution by the Board.

DIVISION 12

BOARD'S OWN MOTION JURISDICTION

438-12-001 DEFINITIONS.

(1) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance, or its delegate for a particular matter.

(2) "Own Motion Claim" means a request by or on behalf of a claimant whose aggravation rights have expired for compensation for temporary disability, or medical services for a claim with date of injury before January 1, 1966, where there is a worsening of a compensable injury that requires inpatient or outpatient surgery or other treatment requiring hospitalization.

(3) "Own Motion Insurer," "Insurer" and "Paying Agent" mean a guaranty contract insurer or self-insured employer which is or may be responsible for payment of compensation under the provisions of ORS 656.278.

438-12-016 COMMUNICATION WITH BOARD AND PARTIES IN OWN MOTION CASES.

A copy of any document in an own motion proceeding, including correspondence, directed to the Board shall be simultaneously mailed to all other parties involved in a claim or, if a party is currently represented by an attorney, to the party's attorney.

438-12-018 APPLICABILITY OF RULES.

These rules apply only to claims in which a request for compensation under the Board's own motion is made on or after January 1, 1988. All claims reopened under ORS 656.278 on or before December 31, 1987 shall be continued and closed by the Board under the law and rules in effect on the date the claim was ordered reopened. All requests for compensation under the Board's own motion pending on January 1, 1988, but not reopened as of that date, shall be processed by the Board under the law in effect on that date and these rules, except that own motion insurers are relieved of the duty of initial processing of such claims.

438-12-020 REQUIREMENT FOR INSURER ACTION ON OWN MOTION CLAIM.

An own motion insurer shall be responsible for processing any written request for additional compensation for worsened conditions resulting from the original injury, signed by or on behalf of a claimant, that contains sufficient information to identify the claimant and the claim.

438-12-025 INSURER TO PROCESS OWN MOTION CLAIM.

(1) All own motion claims shall first be directed to and processed by the own motion insurer. The own motion insurer shall forward an information copy of each own motion claim to the Board within seven (7) days of receipt of the claim.

(2) Not later than the 60th day after receipt of an own motion claim, the own motion insurer shall notify the claimant and the Board in writing whether the own motion insurer recommends that the claim be reopened or denied.

(3) Nothing in these rules shall prevent any insurer from voluntarily reopening any claim to provide benefits or grant additional medical or hospital care to the claimant; however, reimbursement from the Reopened Claims Reserve shall not be prescribed by the Board unless the claim qualifies for own motion relief under ORS 656.278 and these rules.

438-12-030 INSURER RECOMMENDATION OF REOPENING OR DENIAL OF CLAIM

In all cases, the own motion insurer shall, within 60 days of receiving an own motion claim, make a written recommendation to the Board whether the claim should be reopened or denied. A copy of the recommendation shall be mailed to the claimant and the claimant's representative, if any.

(1) A recommendation that a claim be reopened shall state:

(a) That the insurer recommends that the claim be reopened;

(b) That temporary disability compensation is recommended, the rate of payment of temporary disability compensation and when the first payment should be due.

(2) A recommendation that claim reopening be denied shall state:

(a) That the own motion insurer recommends that the claim be denied;

(b) A concise statement of the reason(s) for the recommendation; and

(c) Whether or not medical services are being provided in connection with the claim.

(3) The following notice shall appear on all recommendations for reopening or denial in prominent or bold-face type:

"THIS RECOMMENDATION WILL BE REVIEWED BY THE WORKERS' COMPENSATION BOARD. COPIES OF ALL EVIDENCE CONSIDERED BY US WILL BE SENT TO THE BOARD AND TO YOU IF YOU REQUEST THEM. YOU MAY SEND OTHER MATERIALS TO THE BOARD BY MAILING THEM TO THE BOARD AT 480 CHURCH STREET, S.E., SALEM, OREGON 97310. ANY MATERIAL MUST BE SUBMITTED WITHIN 14 DAYS TO BE CONSIDERED. YOU MAY HAVE AN ATTORNEY OF YOUR CHOICE, WHOSE FEE WILL BE LIMITED TO A PERCENTAGE OF ANY MORE COMPENSATION YOU MAY RECEIVE."

438-12-032 DESIGNATION OF PAYING AGENT IN OWN MOTION CLAIM.

(1) Except as provided in the next section, when Compliance notifies the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180 if the Board consents to the order where one or more insurers involved in the proceeding is subject to ORS 656.278, the Board shall notify Compliance within ten (10) days whether it consents to the order.

(2) If the parties do not agree and the Board is unable to determine from the information furnished by Compliance whether the claimant would be entitled to own motion relief if the own motion insurer was responsible for payment of compensation, the Board shall require the parties to state their positions in writing and submit any evidence upon which they rely to the Board within ten (10) days. The time for the Board's response to Compliance is suspended during this process.

(3) If the Board finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation, it shall notify Compliance that it consents to the order designating a paying agent. For the purposes of ORS 656.625 and OAR 436, Division 45, the Board's written consent to entry of the order designating a paying agent is an order reopening a claim under ORS 656.278 and these rules if the designated paying agent is an own motion insurer.

(4) Upon entry of the order designating a paying agent, the responsibility issue shall be referred to arbitration under ORS 656.307 and Division 14 of these rules. If the arbitrator finds the own motion insurer to be the responsible party, the filing by a party of a request for Board or judicial review shall not stay the payment of compensation to a claimant.

438-12-035 PAYMENT OF COMPENSATION FOR TEMPORARY DISABILITY

(1) The insurer shall make the first payment of temporary disability compensation within 14 days from the date of an order of the Board reopening the claim.

(2) Temporary disability compensation shall continue to be paid under the relevant statutory provisions and regulations established by the Director for all other claims until termination of such benefits is authorized by these rules, except in cases subject to OAR 438-12-055(2) where claim closure by Evaluation is required under the provisions of ORS 656.268.

438-12-040 ACTION BY BOARD AFTER INSURER RECOMMENDATION

(1) Except as provided in OAR 438-12-050, within a reasonable time after receipt of the insurer's recommendation and additional materials, if any, from the claimant the Board may:

(a) Issue its order based upon the reports submitted by the parties;

(b) Request additional information from one or more of the parties; or

(c) Refer the matter to the Hearings Division for an evidentiary hearing and recommended findings of fact and conclusions.

438-12-050 BOARD WILL ACT UNLESS CLAIMANT HAS NOT EXHAUSTED OTHER AVAILABLE REMEDIES.

The Board will act promptly upon a request for relief under the provisions of ORS 656.278 and these rules unless:

(1) The claimant has available administrative or judicial remedies under the provisions of ORS 656.273;

(2) The claimant's condition is the subject of a contested case under ORS 656.283 to 656.298 or an arbitration under ORS 656.307 and Division 14 of these rules; or

(3) The claimant has an available remedy under the provisions of ORS 656.340.

438-12-052 CONTENT OF BOARD'S ORDER; REIMBURSEMENT FROM REOPENED CLAIMS RESERVE.

(1) The Board's order shall state whether the claim is reopened or the request for reopening is denied. If reopening is denied, the order shall state the factual and legal bases for the denial. Copies of the Board's order shall be mailed to the claimant and the claimant's representative, if any, the own motion insurer and its representative, if any, and Compliance.

(2) A claim shall not be ordered reopened under ORS 656.278 and these rules unless it is established by a preponderance of the evidence that all aggravation rights on the compensable injury have expired and the claimant has experienced a worsening of the compensable condition that requires inpatient or outpatient surgery or other treatment that requires hospitalization. An order reopening a claim under ORS 656.278 shall state:

(a) That the claim is ordered reopened;

(b) The date on which compensation for temporary disability shall begin;

(c) That compensation for temporary total disability shall terminate when the claimant returns to his or her regular work at his or her regular wage or is medically stationary, whichever is earlier; and

(d) For claims with date of injury prior to January 1, 1966, the specific medical services for which payment is authorized.

(3) An order reopening a claim shall include the following language: "Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45."

438-12-055 CLOSURE OF CLAIMS REOPENED UNDER ORS 656.278.

(1) When a claim has been ordered reopened by the Board and the medical reports indicate to the insurer that the claimant's condition has become medically stationary the claim shall be closed by the insurer, without the issuance of an order of the Board. In all such cases the insurer shall issue a notice of claim closure to the claimant and the claimant's representative, if any, the Board and Compliance. The notice shall inform the claimant of the amount and duration of temporary disability compensation and shall include the following notice in prominent or bold face type:

"IF YOU THINK THIS CLAIM CLOSURE IS WRONG, YOU MAY ASK THE WORKERS' COMPENSATION BOARD TO REVIEW IT AND DECIDE WHETHER YOU ARE ENTITLED TO MORE COMPENSATION. YOU MUST ASK FOR A REVIEW WITHIN 60 DAYS OF THE DATE OF THIS NOTICE OR YOUR RIGHTS TO CONTEST THIS NOTICE WILL BE LOST. YOU MAY ASK FOR A REVIEW BY WRITING TO THE BOARD AT 480 CHURCH STREET, S.E., SALEM, OREGON 97310. YOU MAY HAVE AN ATTORNEY OF YOUR CHOICE, WHOSE FEE WILL BE LIMITED TO A PERCENTAGE OF ANY MORE COMPENSATION YOU MAY BE AWARDED."

(2) A claim reopened by order of the Board pursuant to ORS 656.278 and these rules shall be submitted to Evaluation for determination and closure under the provisions of ORS 656.268 if, at the time the own motion claim was made, the claimant had the right to appeal from a Determination Order issued by Evaluation.

438-12-060 BOARD REVIEW OF INSURER CLOSURE.

(1) The request for a review shall be in writing, signed by the claimant or the claimant's representative and shall include the claimant's name and mailing address, a statement that a review is requested, the name of the insurer and the date of the claim closure. The request must be received by the Board within 60 days of the mailing date of the insurer claim closure to be considered. The Board shall notify all parties that a review has been requested.

(2) Within 15 days after notification from the Board that a review has been requested, the insurer shall submit legible copies of all materials considered by the insurer in closing the claim to the Board and to the claimant or the claimant's representative.

(3) The claimant may submit additional materials, including written argument to the Board. Such materials must be submitted within 15 days from the date the insurer submits the materials relied upon in closing the claim to be considered.

(4) The insurer may submit written argument in response to the claimant's argument within 10 days of the mailing of claimant's argument.

(5) In appropriate cases, the Board may refer a matter to the Hearings Division for an evidentiary hearing and recommended findings of fact and conclusions.

(6) The Board shall issue its decision within a reasonable time after receipt of all materials from the parties or recommended findings and conclusions from the Hearings Division.

438-12-065 RECONSIDERATION; JUDICIAL REVIEW OF OWN MOTION ORDERS.

All final orders issued by the Board under the provisions of ORS 656.278 and these rules shall contain the following notice:

> "NOTICE TO ALL PARTIES: The claimant may appeal from this order if it decreases or terminates a former award. The insurer may appeal from this order if it increases a former award. The appeal must be filed with the Court of Appeals, Supreme Court Building, Salem, Oregon 97310 within 30 days of the date of this order."

DIVISION 13

EXPEDITED CLAIMS SERVICE

438-13-005 EXPEDITED CLAIMS SERVICE ESTABLISHED.

Pursuant to the mandate of 1987 Or Laws, c. 884, sec. 18, there is established within the Hearings Division the Expedited Claims Service. The purpose of the Expedited Claims Service is to provide for prompt, informal dispute resolution and to insure fair and just treatment of workers in all proceedings.

438-13-010 REFERRAL OF REQUEST FOR HEARING TO EXPEDITED CLAIMS SERVICE.

(1) A request for hearing filed with the Hearings Division shall be referred to the Expedited Claims Service if:

(a) The request for hearing does not involve the compensability of a claim, aggravation of a previously accepted claim or responsibility between insurers for a condition resulting from an accidental injury or occupational disease; and

(b) (i) The only issue in the case is entitlement to penalties and/or related attorney fees; or

(ii) The total amount in controversy, exclusive of penalties and/or related attorney fees is $1,000 or less.

(2) If the referee finds from the evidence after the hearing begins that the amount in controversy is more than $1,000, exclusive of penalties and/or related attorney fees, the referee shall refer the case for decision under the ordinary hearing process. With the consent of the referee, the parties may agree on the oral record to proceed with the hearing as referred to the ordinary hearing process without further delay. Such an agreement to proceed is a waiver of any claim of defect as to notice of hearing or issues.

438-13-015 DETERMINATION OF AMOUNT IN CONTROVERSY.

(1) Subject to section (2) of this rule, for the purposes of assignment to the Expedited Claims Service, the amount in controversy shall be presumed to be less than $1,000 if the party requesting the hearing so states on a form prescribed by the Board or in the request for hearing.

(2) The amount in controversy shall be presumed to be more than $1,000 if the issues presented for resolution include:

(a) The extent of a claimant's unscheduled permanent partial disability; or

(b) Compensation for temporary disability in excess of 30 days.

438-13-020 REPRESENTATION OF PARTIES IN EXPEDITED CLAIMS.

(1) A claimant need not be represented by any other person in proceedings before the Expedited Claims Service.

(2) A claimant may be represented by an attorney or by an individual who is not an attorney in proceedings before the Expedited Claims Service.

(3) It shall be presumed that a claimant is not represented by any other individual unless the claimant or the individual representing the claimant notifies the Hearings Division and the insurer, in writing:

(a) That the claimant is represented by another individual;

(b) Of the name, mailing address and telephone number of the individual representing the claimant; and

(c) Whether the individual representing the claimant is an attorney.

(4) Notwithstanding 438-06-100, an insurer may be represented by an authorized claims representative at any proceeding under the Expedited Claims Service.

438-13-025 NOTICE OF HEARING DATE.

The Hearings Division shall mail a notice of hearing date to all parties and to all other individuals who represent the parties. The hearing shall be scheduled for a date that is not less than 15 days from the mailing of the notice of hearing nor more than 30 days from the date of receipt of the request for hearing by the Hearings Division.

438-13-030 HEARINGS IN EXPEDITED CLAIMS; INFORMAL DISPUTE RESOLUTION.

(1) OAR 438-07-015 does not apply to the Expedited Claim Service. The insurer's representative shall bring all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim to the hearing. The referee shall, before convening the hearing, determine whether the case may be resolved informally or decided on agreed facts.

(2) If the case can be decided on agreed facts, the agreement of the facts shall be stated on the oral record. No testimony shall be taken and the record shall be closed upon oral argument, if any, on behalf of the parties.

(3) If the case cannot be decided on agreed facts, the referee shall so state on the oral record of the hearing or in the order. The referee shall admit into evidence those documents furnished by the insurer that are relevant to a determination of the dispute, along with any other relevant documents offered by the claimant.

(4) It is the intent of the Board in adopting these rules that all cases under the Expedited Claim Service be heard and decided quickly and fairly. Referees shall take an active role in the hearing.

(5) Unless more time is allowed in advance after a showing of good cause, no hearing under the Expedited Claims Service shall be scheduled to exceed one hour in duration.

438-13-035 POSTPONEMENTS AND CONTINUANCES.

(1) A hearing under the Expedited Claims Service shall not be postponed except upon a showing of extraordinary circumstances beyond the control of the party requesting the postponement. "Extraordinary circumstances" shall be as defined in 438-06-081 except that unavailability of an individual who represents an insurer shall not be a reason to postpone a hearing under any circumstances and unavailability of an individual who represents a claimant shall not be a reason to postpone a hearing under the Expedited Claims Service unless the referee finds that

the claimant is physically or mentally incapable of representing himself or herself at the hearing.

(2) A hearing under the Expedited Claims Service may be continued for further proceedings only if the referee finds and states on the oral record that a continuance is required to achieve substantial justice.

438-13-040 ORDER OF REFEREE; REVIEW.

(1) The referee shall issue an order deciding the case not later than ten (10) days after the closing of the record. The order may adopt by reference findings and conclusions stated on the oral record.

(2) The referee's order shall include a notice of rights of review by the Workers' Compensation Board under the provisions of ORS 656.295.

DIVISION 14

ARBITRATION OF DISPUTES AS TO INSURER RESPONSIBILITY

438-14-005 DEFINITION. For the purposes of this Division, "arbitrator" means a referee assigned by the Board to hear and decide a controversy as to which of two or more insurers is responsible for paying compensation to or on behalf of a claimant.

438-14-010 ASSIGNMENT TO ARBITRATION; APPOINTMENT OF ARBITRATOR.

(1) Upon receipt by the Board of an order designating a paying agent issued by Compliance under the provisions of ORS 656.307 and OAR 436-60-180, the Board shall, without further request from Compliance or any party, establish an arbitration file.

(2) The Board hereby delegates to the presiding referee the appointment of referees to act as arbitrators. Upon the opening of an arbitration file, the presiding referee shall appoint a referee as an arbitrator. Once appointed, the arbitrator shall be responsible for all further activity in the case, including the setting of the time and place for the arbitration hearing, if required.

(3) OAR 438-06-095 shall apply to the appointment and removal of arbitrators.

438-14-015 FUNCTION OF ARBITRATOR. The arbitrator shall attempt to resolve the dispute between the parties as informally, expeditiously and as inexpensively as practicable.

438-14-020 SEGREGATION OF MATTERS CONCERNING CLAIMS. If the arbitrator finds that inclusion of matters concerning a claim as defined in ORS 656.704(3) within an arbitration proceeding under ORS 656.307 and these rules would delay or hinder the resolution of either the arbitration or the matters concerning a claim, the arbitrator may, on the motion of a party or on his or her own motion, segregate the issues. If the issues are so segregated under this rule, all matters concerning the claim or

claims shall be referred for hearing under ORS 656.283 or 656.291 and the arbitration shall proceed with responsibility and related attorney fees as the sole issues.

438-14-025 HEARINGS; EVIDENCE; DECISION ON RECORD.

(1) If, within 45 days from his or her appointment, the arbitrator determines that the responsibility dispute, or any other matter not segregated, cannot be resolved informally, he or she shall schedule a hearing. Not less than 10 days notice of the date, time and place of the hearing shall be given all parties and Compliance. The notice of the arbitration hearing shall include a notice to the claimant that he or she is required to notify the arbitrator at least three (3) days prior to the hearing whether he or she intends to appear at the hearing.

(2) If the claimant notifies the arbitrator that he or she does not intend to appear at the hearing or if the claimant has not contacted the arbitrator as required by the notice, any party or the arbitrator may compel appearance of the claimant by subpoena. If no party compels appearance of the claimant in such cases, the parties are deemed to have waived examination of the claimant.

(3) An oral record of all proceedings in an arbitration hearing shall be made, but need not be transcribed unless a review of the arbitration decision is requested by a party.

(4) The parties may agree that the arbitrator may decide the responsibility dispute on the basis of agreed facts and argument of the parties or their representatives, or by resorting solely to the documentary record and argument of the parties or their representatives.

(5) The arbitrator's decision shall be mailed not later than 30 days after the submission of the case for decision. The order shall be styled and captioned in the same manner as other orders of the Hearings Division except that the title of the document shall be "Arbitrator's Decision."

438-14-030 MONETARY ADJUSTMENTS AMONG PARTIES. The arbitrator shall order all appropriate monetary adjustment between insurers in the arbitration decision. "Appropriate monetary adjustments" are those that may result from a decision that a party other than the paying agent designated by Compliance is the responsible party. No adjustment shall be made by the arbitrator for any payments made prior to the appointment of the paying agent or subsequent to the mailing date of the arbitration decision.

438-14-035 COSTS OF ARBITRATION. Costs of the arbitration to be assessed by Compliance are established as the average direct and indirect costs to the Board of processing a contested case under the Workers' Compensation Law. As of the effective date of these rules, the costs of arbitration of a case in which no hearing is convened is $104 and the costs of arbitration of a case in which a hearing is convened is $627. The Board shall, by bulletin, make necessary annual adjustments in the established costs of arbitration.

DIVISION 15

ATTORNEY FEES

438-15-001 STATEMENT OF POLICY. The Legislative Assembly has recognized that workers, employers, self-insured employers and insurers litigating disputes under the Workers' Compensation Law of this State usually engage the services of attorneys to marshal, present and advocate their cases before, during and after formal hearings, on review by the Board and before the appellate courts. It also has been a requirement that corporations and state agencies be represented by attorneys in proceedings before the Hearings Division and the Board. The law has provided for the regulation of fees paid to attorneys representing injured workers in the delivery of benefits under the Workers' Compensation Law. The requirements of 1987 Oregon Laws, Chapter 884, section 35, is that all attorney fees, whether incurred for representation of workers or employers and insurers, be subject to approval by the Board. In accordance with these requirements, and after consultation with the Board of Governors of the Oregon State Bar, the Board adopts these rules relating to the allowance or award of attorney fees in contested cases under the Workers' Compensation Law.

438-15-002 PRIOR RULES REPEALED. OAR 438-47-000 through 438-47-095, adopted by WCB Admin. Order 1-1979, are repealed effective midnight December 31, 1987.

438-15-003 AUTHORITY FOR ADOPTION; EFFECTIVE DATE.

(1) These rules are adopted pursuant to ORS 656.388, as amended by 1987 Or. Laws, c. 884, sec. 35, and ORS 656.593, under the general rulemaking authority of the Board pursuant to ORS 656.726(4).

(2) These rules are effective as of January 1, 1988.

438-15-005 DEFINITIONS. In addition to the definitions set forth in 438-05-040:

(1) "Approved fee" means an attorney fee paid out of a claimant's compensation.

(2) "Assessed fee" means an attorney fee paid to a claimant's attorney by an insurer or self-insured employer in addition to compensation paid to a claimant.

(3) "Attorney" means a member of the Oregon State Bar.

(4) "Attorney fee" means payment for legal services performed by an attorney on behalf and at the request of a claimant, insurer or self-insured employer under ORS Chapter 656.

(5) "Client paid fee" means an attorney fee paid by an insurer or self-insured employer to its attorney.

(6) "Compensation" means all benefits, including medical services, provided for a compensable injury to a subject worker or the beneficiaries of a subject worker pursuant to ORS Chapter 656.

(7) "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.

(8) "Court" means the Court of Appeals or Supreme Court of the State of Oregon.

438-15-010 GENERAL PRINCIPLES.

(1) Attorney fees for an attorney representing a claimant, insurer or self-insured employer shall be authorized only if an executed attorney retainer agreement has been filed with the referee, Board or court.

(2) Attorney fees for an attorney representing a claimant shall be paid out of the claimant's compensation award except as provided by ORS 656.307, 656.382 and 656.386.

(3) An approved fee awarded or allowed to an attorney representing a claimant shall be a lien upon the claimant's compensation.

(4) Payment of attorney fees for attorneys representing insurers and self-insured employers are the responsibility of the insurer or self-insured employer. Collection of any such fee shall be the responsibility of the attorney.

(5) Except as otherwise provided in these rules, an assessed fee or client paid fee shall not be authorized by a referee, the Board or a court unless the attorney requesting authorization for payment of the fee files a statement of services on a form prescribed by the Board, or complies with the rules of the court for matters involving authorization of attorney fees.

(6) In any case where a referee, the Board or a court is required to determine a reasonable attorney fee, the following factors shall be considered:

(a) The time devoted to the case;

(b) The complexity of the issue(s) involved;

(c) The value of the interest involved;

(d) The skill and standing of the attorneys;

(e) The nature of the proceedings;

(f) The result secured for the represented party;

(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

(h) The assertion of frivolous issues or defenses.

(7) Percentage limitations on fees established by these rules apply to the amount of compensation paid the claimant exclusive of medical, hospital or other expenses of treatment.

438-15-015 CHARGE FOR LEGAL SERVICES MUST BE AUTHORIZED.

No charge for legal services for representation of claimants, insurers or self-insured employers in connection with any claim under ORS Chapter 656 is valid unless the charge has been authorized in accordance with ORS 656.307, 656.382 to 656.390 or 656.593 or these rules.

438-15-020 ATTORNEY FEES FOR ATTORNEYS REPRESENTING INSURERS AND SELF-INSURED EMPLOYERS.

(1) Attorneys representing insurers and self-insured employers are authorized to submit statements for legal services performed in connection with a claim under ORS Chapter 656 directly to the client without further authorization from a referee or the Board if no request for hearing has been filed and the total charges for legal services do not exceed $500, exclusive of costs.

(2) In all other cases the referee, Board or court shall authorize a client-paid fee that is reasonable, considering the factors set forth in 438-15-010(6). The fee authorized shall not exceed that agreed to in the retainer agreement.

438-15-025 MAXIMUM ATTORNEY FEES OUT OF COMPENSATION.

Except in situations where a claimant's attorney fee is an assessed fee, in settlement of disputed claims and in cases under the third-party law, unless there is a finding in a particular case by a referee, the Board or a court that extraordinary circumstances justify a higher fee, the established fees for attorneys representing claimants are as set forth in 438-15-040, 438-15-045, 438-15-055(1), 438-15-060(1) and 438-15-080.

438-15-027 TIME FOR FILING STATEMENT OF SERVICES.

(1) The following subsections apply only to assessed fees, client paid fees and extraordinary approved fees for services before the referee or the Board:

(a) A statement of services for a proceeding before a referee shall be filed within 15 days of the conclusion of the proceeding.

(b) A request for authorization of an attorney fee under 438-15-030 shall be filed within 30 days after the legal services are concluded.

(c) A statement of services for proceedings before the Board in own motion matters shall be filed within 30 days after mailing of the own motion order.

(d) A statement of services for proceedings on Board review of a referee's order shall be filed within 15 days after the filing of the last brief to the Board.

(2) A statement of services for proceedings before a court shall be filed in accordance with the rules of the court.

438-15-030 ATTORNEY FEES WHEN THERE IS NO HEARING.

(1) If an attorney is instrumental in obtaining compensation for a claimant without a hearing before a referee, a reasonable attorney fee may be approved or assessed. The amount of the fee shall be determined in a summary proceeding by a referee.

(2) A referee may approve a reasonable attorney fee for a claimant's attorney when a claim is submitted to Evaluation for redetermination of disability by agreement of the parties. Unless the parties agree otherwise, the fee shall be paid out of any increased compensation awarded to the claimant by Evaluation.

(3) If a client paid fee is not authorized under 438-15-020(1), the referee may authorize a client paid fee in accordance with 438-15-010(5) and (6).

438-15-035 ATTORNEY FEES WHEN A CLAIMANT REQUESTS A HEARING ON A DENIED CLAIM.

If, after a hearing requested by the claimant, the referee orders the acceptance of a previously denied claim, the referee shall award a reasonable assessed fee. This rule applies to denials of original claims for accidental injury and occupational disease, denials of aggravation and partial denials.

438-15-040 ATTORNEY FEES WHEN A CLAIMANT REQUESTS A HEARING ON EXTENT OF PERMANENT DISABILITY.

(1) If, after a hearing requested by the claimant, the referee awards additional compensation for permanent partial disability the referee shall approve a fee of 25 percent of the increased compensation, but not more than $2,800, to be paid out of the increased compensation.

(2) If, after a hearing requested by the claimant, the referee awards compensation for permanent total disability the referee shall approve a fee of 25 percent of the increased compensation, but not more than $4,600, to be paid out of the award for permanent total disability.

(3) Notwithstanding the preceeding subsections, no attorney fee shall be approved to be paid out of compensation if an assessed fee is awarded under the provisions of ORS 656.382(4).

438-15-045 ATTORNEY FEES WHEN A CLAIMANT REQUESTS A HEARING ON EXTENT OF TEMPORARY DISABILITY.

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

438-15-050 ATTORNEY FEES IN CONNECTION WITH DISPUTED CLAIM SETTLEMENTS.

When a denied and disputed claim is settled under the provisions of ORS 656.289(4) and OAR 438-09-010, an attorney fee may be approved by the referee, the Board or a court in an amount up to 25 percent of the first $12,500 of the settlement proceeds

plus 10 percent of any amount of the settlement proceeds in excess of $12,500. Under extraordinary circumstances a fee may be authorized in excess of 25 percent of the settlement proceeds. OAR 438-15-010(5) does not apply to attorney fees authorized under this rule.

438-15-055 ATTORNEY FEES WHEN A CLAIMANT REQUESTS REVIEW BY THE BOARD.

(1) If a claimant requests review of a referee's order on the issue of compensation for temporary or permanent disability and the Board awards additional compensation, the Board shall approve a fee of 25 percent of the increased compensation, provided that the total of fees approved by the referee and the Board shall not exceed $3,800, except in cases where the Board awards compensation for permanent total disability, in which cases the total of fees awarded by the referee and the Board shall not exceed $6,000.

(2) If a claimant requests review of a referee's order that upheld a denial of a claim and the Board orders the claim accepted, the Board shall assess a reasonable attorney fee to be paid by the insurer or self-insured employer to the claimant's attorney.

438-15-060 ATTORNEY FEES WHEN A CLAIMANT REQUESTS JUDICIAL REVIEW.

(1) If a claimant requests judicial review of an order of the Board on the issue of compensation for temporary or permanent disability and the court awards additional compensation, the court shall approve a fee of 25 percent of the increased compensation.

(2) If a claimant requests judicial review of an order of the Board that upheld a denial of a claim and the court orders the claim accepted, the court shall assess a reasonable attorney fee to be paid by the insurer or self-insured employer to the claimant's attorney.

438-15-065 ATTORNEY FEES WHEN INSURER OR SELF-INSURED EMPLOYER REQUESTS A HEARING.

If an insurer or self-insured employer requests a hearing or otherwise seeks a reduction in compensation and the referee does not reduce the compensation, the referee shall award a reasonable assessed fee.

438-15-070 ATTORNEY FEES WHEN INSURER OR SELF-INSURED EMPLOYER REQUESTS OR CROSS-REQUESTS REVIEW BY THE BOARD.

If an insurer or self-insured employer requests or cross-requests review of the referee's order and the Board does not disallow or reduce the claimant's compensation, the Board shall award a reasonable assessed fee.

438-15-075 ATTORNEY FEES WHEN INSURER OR SELF-INSURED EMPLOYER REQUESTS OR CROSS-REQUESTS JUDICIAL REVIEW.

If an insurer or self-insured employer requests or cross-requests judicial review of an order of the Board the Board's order is affirmed by the court, the court shall assess a reasonable attorney fee to be paid by the insurer or self-insured employer to the claimant's attorney.

438-15-080 ATTORNEY FEES IN OWN MOTION CASES.

If the claimant requests review of an insurer or self-insured employer closure under OAR 438-12-055 and the Board orders increased compensation for temporary disability, the Board shall approve a fee of 25 percent of the increased compensation, not to exceed $1,050. OAR 438-15-020 applies to client paid fees in own motion cases.

438-15-082 TIMELY PAYMENT OF ATTORNEY FEES.

(1) An approved attorney fee shall be paid within the time required for payment of the compensation out of which the approved fee is to be paid.

(2) Subject to ORS 656.313(4), an assessed attorney fee shall be paid within 30 days of the date the order authorizing the fee becomes final.

438-15-085 PAYMENT OF ATTORNEY FEES OUT OF COMPENSATION; FEE NOT SUBJECT TO OFFSET.

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

(2) An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon prior overpayment of compensation to the claimant.

438-15-090 ATTORNEY FEES IN ARBITRATION OF RESPONSIBILITY CASES.

If the claimant appears in any arbitration under Division 14 of these rules and actively and meaningfully participates in the arbitration through an attorney, the arbitrator may require the payment of a reasonable assessed fee to be paid by the insurer or self-insured employer determined by the arbitrator to be the party responsible for paying compensation.

438-15-095 ATTORNEY FEES IN THIRD-PARTY CASES.

Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 to 656.595 is authorized. OAR 438-15-010(5) does not apply to attorney fees authorized under this rule.

438-15-100 REPORTING REQUIREMENT FOR INSURERS AND SELF-INSURED EMPLOYERS.

Insurers and self-insured employers shall make an annual report to the Board reporting attorney fees, attorney salaries and all other costs of legal services paid pursuant to ORS Chapter 656. The report shall be submitted on forms furnished by the Board for that purpose. The first report under these rules shall be filed not later than March 31, 1988 for the calendar year 1987, to the extent data are available. Subsequent reports shall be filed beginning not later than January 31, 1989 and not later than January 31 of each calendar year thereafter for the preceding calendar year.

CERTIFICATE AND ORDER FOR FILING TEMPORARY ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

DEC 18 2 51 PM '87

SECRETARY OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of **TEMPORARY** rule(s) adopted on December 18, 1987 (Date)

by the WORKERS' COMPENSATION BOARD (Department) (Division)

to be effective December 18, 1987 (Date) through June 1, 1988 (Date)

The within matter having come before the WORKERS' COMPENSATION BOARD (Department) (Division) after

all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken: (List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

Adopted (New Total Rules): OAR 438-07-022

Amended (Existing Rules):

Suspended (Total Rules Only):

RECEIVED
DEC 18 1987
LEGISLATIVE COUNSEL'S OFFICE

as Administrative Rules of the WORKERS' COMPENSATION BOARD (Department) (Division)

DATED this 18th day of December, 19 87

( ) This Order amends TEMPORARY Order No.(s):
Filed:
NOTE. The Expiration date of this Order remains the same as the original Order.

By: (Authorized Signer)

Title: Chairman Member Member

Statutory Authority: ORS 656.726(4) or

Chapter(s) , Oregon Laws 19 or

House Bill(s) , 19 Legislature; or Senate Bill(s) , 19 Legislature

Subject Matter: Rule of Practice and Procedure for Contested Cases under the Workers' Compensation Law. Testimony by Telephone Prohibited.

Statement of Need Attached: X Emergency Justification Attached: X Do you intend to adopt this rule Permanently? YES X NO ( )

If so, have you filed Notice of Proposed Rulemaking for publication in the **Oregon Bulletin**? YES ☐ NO X

For Further Information Contact: T. Lavere Johnson, Chairman (Rule Coordinator) Phone: 378-3308

BEFORE THE WORKERS' COMPENSATION BOARD

OF THE STATE OF OREGON

In the Matter of the Adoption of a Temporary Rule of Practice and Procedure in Contested Cases Under the Workers' Compensation Law relating to Taking of Testimony by Telephone, OAR 438-07-022	))))))	WCB Admin. Order 6-1987 ORDER OF ADOPTION

Pursuant to the procedures provided by ORS 183.335(5) and under the general authority of the Workers' Compensation Board to make rules of practice and procedure for contested cases under the Workers' Compensation Law, ORS 656.726(4), the Board has proposed the temporary adoption of OAR 438-07-022, prohibiting the taking of testimony by telephone in contested case hearings. The Board finds that the rule is necessary to prevent prejudice to parties to contested case hearings and is in the public interest to acheive consistency in and accurate recording of such hearings, and that the rule is reasonable and necessary to protect the interests of the parties, potential parties and witnesses in the hearings. The Board hereby adopts OAR 438-07-022, attached hereto as Exhibit "A" and hereby made a part of this order, to be effective upon filing with the Secretary of State pursuant to ORS 183.355(2)(b).

Dated this 18th day of Decemeber, 1987.

WORKERS' COMPENSATION BOARD

T. Lavere Johnson, Chairman

Evelyn S. Ferris, Member

Lynn-Marie Crider, Member

BEFORE THE WORKERS' COMPENSATION BOARD

OF THE STATE OF OREGON

In the Matter of the Adoption of a Temporary Rule of Practice and Procedure in Contested Cases Under the Workers' Compensation Law relating to Taking of Testimony by Telephone, OAR 438-07-022	))))))	CITATION OF STATUTORY AUTHORITY, STATEMENT OF NEED AND STATEMENT OF FISCAL IMPACT

1. Citation of Statutory Authority. The Board's general authority to make rules of practice and procedure for contested cases under the Worker's Compensation Law, ORS 656.726(4), and the Administrative Procedures Act, ORS 183.310 to 183.410.

2. Statement of Need for Rule. The referees of the Hearings Division of the Board have received numerous requests that the testimony of witnesses in contested case hearings be taken by telephone. The referees have taken inconsistent approaches to the requests, some allowing the procedure and others not allowing it. The Board concludes that a uniform approach must be taken. The Board further concludes that the taking of testimony by telephone is inconvenient, cumbersome and an ineffective manner of receiving live evidence in most cases. In general, the Board's facilities for holding hearings are not equipped to permit the making of an accurate record of telephone testimony. Having thoroughly considered the alternatives, the Board concludes that the fairest manner of dealing with the subject of telephone testimony is to prohibit it in all cases.

3. Principal Documents Relied Upon. ORS Chapter 656 and OAR Chapter 438.

4. Statement of Fiscal Impact. Based upon information reasonably available to the Board, the proposed temporary rule will have no fiscal impact upon state agencies, units of local government or the public. There is no fiscal impact on businesses of any kind.

Dated December 18, 1987.

WORKERS' COMPENSATION BOARD

By _____
T. Lavere Johnson, Chairman

Exhibit "A"

Temporary Rule of Practice and Procedure

for Contested Cases under the

Workers' Compensation Law

438-07-022 TESTIMONY BY TELEPHONE PROHIBITED. The testimony of a witness at a hearing shall not be taken by telephone.

RECEIVED

CERTIFICATE AND ORDER FOR FILING PERMANENT ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

Dec 23 3 54 PM '87

BARGAINING RIGHTS SECRETARY OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of **PERMANENT** rule(s) adopted on December 23, 1987 (Date)

by the Workers' Compensation Board (Department) (Division)

to become effective January 1, 1988 (Date)

The within matter having come before the Workers' Compensation Board (Department) (Division) after all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

Notice of Intended Action published in Secretary of State's Bulletin: NO ☐ YES☒ Date Published: December 1, 1987

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken: (List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

Adopted:
(New Total Rules)

Amended
(Existing Rules) OAR 438-85-006 to 438-85-870

RECEIVED

Repealed:
(Total Rules Only)

DEC 23 1987

LEGISLATIVE COUNSEL'S OFFICE

as Administrative Rules of the Workers' Compensation Board (Department) (Division)

DATED this 23rd day of December, 19 87

By: (Authorized Signer)

Title: Chairman Member

Statutory Authority: ORS 656.726(4) or

Chapter(s) ..., Oregon Laws 19 ... or

House Bill(s) 3381, 19 87 Legislature; or Senate Bill(s) ..., 19 ... Legislature

Subject Matter: Rules of Practice and Procedure for Contested Cases under the Oregon Safe Employment Act.

For Further Information Contact: T. Lavere Johnson, Chairman (Rule Coordinator) Phone: 378-3308

BEFORE THE WORKERS' COMPENSATION BOARD

OF THE STATE OF OREGON

In the Matter of the Amendment of Oregon Administrative Rules, Chapter 438, Division 85, Rules of Practice and Procedure for Contested Cases under the Oregon Safe Employment Act	)))))	WCB Admin. Order 7-1987 ORDER OF ADOPTION

1. On November 18, 1987 the Workers' Compensation Board ("Board") filed a Notice of Proposed Rulemaking Hearing with the Secretary of State, giving notice of its intent to amend its permanent Rules of Practice and Procedure for Contested Case Hearings under the Oregon Safe Employment Act. The Notice was published in the Oregon Bulletin, Volume 27, number 11, on December 1, 1987, and was mailed to representatives of affected parties as their interests appeared. Pursuant to the notice, a public hearing was conducted by Douglas W. Daughtry, Presiding Referee, on December 16, 1987. The record of the hearing was closed on that date.

2. At the hearing, staff comments were received which related to three additional technical amendments required by the reorganization of the Department of Insurance and Finance. The amendments affect rules 438-85-026(14), 438-85-116(2) and 438-85-211, and were accepted by the Board. Additional staff comments were received that related to substantive changes in the proposed rules. The Board concludes that the proposed substantive changes should be the subject of future rulemaking.

3. Under the authority granted by ORS 656.726(4), the Board finds:

a. That all applicable rulemaking procedures have been followed, and

b. That the rules being adopted are reasonable, necessary and proper.

In accordance with its notice of proposed rulemaking, it is hereby ORDERED

That Rules 438-85-006 through 438-85-870, as set forth on Exhibit "A", attached hereto and hereby incorporated into and made a part of this order, are hereby adopted as permanent rules of the Workers' Compensation Board, to be effective January 1, 1988.

Dated this 23rd day of December, 1987.

WORKERS' COMPENSATION BOARD

T. Lavere Johnson, Chairman

Evelyn S. Ferris, Member

EXHIBIT "A"

OREGON ADMINISTRATIVE RULES

CHAPTER 438. WORKERS' COMPENSATION BOARD

DIVISION 85

RULES OF PRACTICE AND PROCEDURE FOR CONTESTED CASES

UNDER THE OREGON SAFE EMPLOYMENT ACT

TABLE OF CONTENTS

RULES OF PRACTICE AND PROCEDURE FOR CONTESTED CASES UNDER THE OREGON SAFE EMPLOYMENT ACT

SCOPE; POLICY; DEFINITIONS

438-85-006 SCOPE; AUTHORITY.

(1) These rules (OAR 438-85-006 to 438-85-870) govern practice and procedure for all contested cases under the Act.

(2) These rules are authorized by the Act and by ORS chapter 183.

(3) The model rules of procedure adopted by the Attorney General pursuant to ORS 183.341 shall not apply to contested cases under the Act.

438-85-017 BOARD POLICY; LIBERAL CONSTRUCTION.

(1) It is the policy of the Board to provide for the prompt and fair disposition of contested cases, encourage informal settlements consistent with the purposes of the Act, and provide an impartial forum for hearings on cases that cannot be resolved between the parties.

(2) These rules shall be liberally construed to carry out the policy of the Board and the purposes of the Act.

438-85-021 NUMBER.

For the purpose of these rules, the singular includes the plural and the plural includes the singular.

438-85-026 DEFINITIONS.

For the purpose of these rules, unless the context otherwise requires, the following definitions apply:

(1) Act: The Oregon Safe Employment Act (ORS 654.001 to 654.295 and 654.991).

(2) Affected employee: An employee who, in the course and scope of the employee's employment, may be or may have been exposed to a condition or practice described in a citation, correction order or variance. The term also includes a labor union authorized to bargain collectively for affected employees.

(3) APD: The Accident Prevention Division of Department of Insurance and Finance.

(4) Appeal: A written request for a hearing to contest a citation, notice or order issued by APD. Unless the contest otherwise requires, any writing which clearly contests, objects to, or seeks relief from an APD citation, notice or order shall be construed as an appeal.

(5) Board: The Workers' Compensation Board created by ORS 656.712.

(6) Citation: A document issued by APD pursuant to ORS 654.071 to allege a violation. A citation may include a notice of penalty and a correction order.

(7) Contested case: A dispute in which an appeal has been filed.

(8) Correction order: A written APD order which directs a person to stop an alleged violation within a given period of time. The term also includes a Red Warning Notice posted pursuant to ORS 654.082.

(9) Division [Department]: The Workers' Compensation Division [Department] of the Department of Insurance and Finance [created by ORS 656.708].

(10) Director: The Director of the Department of Insurance and Finance.

(11) Document: Any notice, form, letter or other writing relating to a contested case.

(12) Employee: Any individual, including a minor

whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, financial or otherwise, subject to the direction and control of an employer, and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, or any individual who is provided with workers' compensation coverage as a subject worker pursuant to ORS chapter 656, whether by operation of law or by election. See ORS 654.005(5).

(13) Employer: Any person who has one or more employees, or any sole proprietor or member of a partnership who elects workers' compensation coverage as a subject worker pursuant to ORS 656.128. See ORS 654.005(6).

(14) Filed: The receipt of a document by the Hearings Division, except that an appeal will be considered filed upon receipt at any office of the Board or APD [Department].

(15) Hearing: A formal, reported proceeding before a referee of the Hearings Division where the parties to a contested case may present their evidence and arguments on the issues.

(16) Hearings Division: The Hearings Division of the Board.

(17) Party: A person named or admitted as a full participant in a contested case. The term includes APD, a necessary party to all contested cases under the Act.

(18) Penalty: The dollar amount proposed in a written notice by APD as the Director's assessment against a person for an [their] alleged violation.

(19) Person: One or more individuals, legal representatives, partnerships, joint ventures, associations, corporations (whether or not organized for profit), business trusts, or any organized group of persons, including the state, state agencies, counties, municipal corporations, school districts

and other public corporations or subdivisions. See ORS 654.005(8).

(20) Presiding Referee: The referee who presides over the administers the Hearings Division, as provided in ORS 656.724.

(21) Referee: The referee of the Hearings Division, or other qualified member of the Oregon State Bar, who is assigned by the Presiding Referee to a contested case. The term also means the Presiding Referee if a referee has not been assigned to the case or the assigned referee is unavailable.

(22) Representative: Any individual authorized by a party or intervenor to represent the party in a contested case. Any reference to "APD," "defendant," "employee," "employer," "intervenor," "labor union," "party," "petitioner," "plaintiff," or "respondent" includes that person's representative.

(23) Settlement: A written agreement which, when approved by all parties and affirmed by the referee, will amend the contested APD citation, notice or order and dispose of all issues in the case.

(24) Variance: The written authority given by APD to an employer to permit the employer to use a specific alternative means or method to comply with the intent of an occupational safety or health law or rule.

(25) Violation: The breach of a person's duty to comply with an Oregon occupational safety or health law, rule or order.

(26) Withdrawal: A party's complete and unconditional abandonment of its allegations, contentions and participation in a contested case. An APD withdrawal is an abandonment of the entire citation, notice or order that contains the matters appealed from.

438-85-106 WHO MAY APPEAL WHAT.

(1) A person to whom a citation, notice of penalty or correction order is issued may file an appeal to deny the alleged violation, contest the amount of the penalty, or contest the unreasonableness of the correction order.

(2) A person who does not contest the reasonableness of the time as originally set by a correction order, but appeals to APD for an extension of that time, may file an appeal to contest APD's denial of the time extension.

(3) An affected employee may file an appeal to contest the reasonableness of the time allowed by a correction order or to contest a subsequent APD order which modifies that time.

(4) An adversely-affected person, including an affected employee, may file an appeal to contest APD's proposed grant, denial, modification or revocation of a variance.

438-85-111 FORM AND CONTENT OF APPEAL.

(1) An appeal does not have to be in any special form, but it must:

(a) Be in writing;

(b) Identify the particular citation, notice or order that is appealed from, and the person to whom it was issued;

(c) Specify each alleged violation, penalty, correction order, or other APD action that is contested;

(d) State the grounds upon which the appeal is based;

(2) An appeal should include the name, address and telephone number of the appealing party and of the party's respective, if any.

438-85-116 WHERE TO APPEAL.

(1) All appeals should be filed with the Hearings Division at its office [in] at 480 Church Street, S.E., SALEM, OREGON 97310.

(2) An appeal may be delivered to any office of the Board or APD [Department], for forwarding to the Hearings Division, to meet a filing deadline.

438-85-121 WHEN TO APPEAL.

(1) An appeal to contest an alleged violation or a proposed penalty shall be filed within 20 days after the contested APD citation or notice is received by the person to whom it was issued.

(2) An appeal relating to a correction order or a variance shall, except for good cause, be filed within 20 days after the contested order or notice is received by the person to whom it was issued.

438-85-131 COMPUTING TIME PERIODS

Time periods required or allowed by these rules shall be computed in calendar days. The first full day after the time begins to run is counted as the first day. If the last day is a Saturday, Sunday, or State holiday, the period runs until the end of the next business day.

JURISDICTION OVER APPEALS: UNTIMELY APPEALS

438-85-211 JURISDICTION OF HEARINGS DIVISION.

Upon the filing of an appeal with any office of the Board or APD [the Department], the Hearings Division shall have jurisdiction over the contested case.

438-85-216 UNTIMELY APPEALS.

(1) If APD alleges that an appeal was not timely filed, the Hearings Division shall give the parties an opportunity for a hearing on that issue.

(2) If a referee finds that an appeal was not timely filed, and that the Board lacks jurisdiction to grant a hearing on the merits of the case, the referee shall issue an order dismissing the appeal.

PROCEDURES IN RESPONSE TO APPEALS

438-85-306 HEARINGS DIVISION RESPONSE TO APPEAL.

When it receives an appeal, the Hearings Division shall assign a docket number to the case and forward a copy of the appeal to APD with a request for the other documents necessary to establish the contested-case file. A copy of the request shall be mailed to the appealing party.

438-85-311 APD RESPONSE TO APPEAL.

(1) Within five days after it receives a request from the Hearings Division for the documents necessary to establish a contested-case file, APD shall file with the Hearings Division:

(a) A certified true copy of the contested citation, notice or order, and

(b) Where applicable, the original of the application for a variance, request for extended time on a correction order, or other petition that initiated the case.

(2) If APD receives an appeal directly from the appealing party, APD shall promptly forward it to the Hearings Division, together with the other documents necessary to establish the contested-case file.

(3) A letter of transmittal shall accompany documents filed under this rule. The letter shall list the documents being

filed. A copy of the letter shall be mailed by APD to the appealing party.

438-85-316 ACTION ON RECEIPT OF APD DOCUMENTS.

Upon receipt of documents required by rule 85-311, the Hearings Division shall:

(1) Caption the case in accordance with rule 85-506;

(2) Issue to the employer of affected employees, whether or not that employer is the appealing party, a Notice to Employees substantially as set forth in Appendix A of these rules, together with instructions for giving notice of the case to the employer's employees and for filing a certification of such notice, as required by rule 85-416; and

(3) If a party has not done so, request that a representative be designated.

438-85-321 EXPEDITED PROCEEDINGS.

(1) An expedited proceeding may be ordered by the referee, for good cause, upon the motion of any party.

(2) An expedited proceeding shall be ordered by the referee upon the motion of any party in a case in which a correction order relating to a serious violation is being contested.

(3) An expedited proceeding shall be given priority over other proceedings; the referee shall make necessary rulings with respect to the time for filing documents and all other matters, without reference to times set forth in these rules, in order to complete the proceeding in the minimum time consistent with fairness and the needs of the case.

438-85-326 STAY OF CORRECTION ORDER.

When an appeal denies a violation or contests the unreasonableness of a correction order, in good faith and not solely for delay or the avoidance of penalties:

(1) If the contest involves an alleged general violation, the time allowed for correction of the violation shall not run between the day the appeal is filed and the day the correction order becomes final by operation of law or by order of a court.

(2) If the contest involves an alleged serious violation, the referee may, upon motion of a party, for good cause, order a stay of the correction order pending disposition of the case.

PARTIES & REPRESENTATIVES; EMPLOYEE THIRD-PARTY RIGHTS & NOTICE; ACCESS TO DOCUMENTS

438-85-406 NECESSARY PARTIES; ADDING PARTIES.

(1) APD is a necessary party to all contested cases under the Act.

(2) Any person considered necessary by the referee for a full and final determination of the issues in a case may be added as a party.

(3) If the appeal was filed by an employee or labor union, the employer who was issued the contested citation, notice or order shall be considered, and added as, a necessary party.

438-85-411 EMPLOYEE THIRD-PARTY RIGHTS.

(1) Affected employees may elect to participate as third parties in a contested case.

(2) An employee election to become a third party in a case must be filed at least five days before the hearing, if any, on the merits of the case. The referee may allow a later employee appearance only upon a showing of good cause.

(3) The written election to become a third party must show that the person is an affected employee and must state the issues to be raised.

438-85-416 NOTICE OF RIGHTS TO AFFECTED EMPLOYEES.

(1) The employer of affected employees shall, promptly upon receipt of the Notice to Employees provided by the Hearings Division pursuant to rule 85-316:

(a) Post copies of the Notice to Employees, together with copies of the contested APD citation, notice or order, in a conspicuous manner in a sufficient number of places convenient for affected employees, until the case is closed; and

(b) Deliver or mail a copy of the Notice to Employees to each labor union, if any, authorized to bargain collectively for affected employees.

(2) An employer may satisfy the posting requirement of this rule by personally delivering or by mailing a copy of the Notice to Employees and the contested APD citation, notice or order to each of the employer's employees.

(3) The employer shall certify that all affected employees have been given notice in accordance with this rule. This certification shall state the date and manner of giving notice and shall be mailed to the Hearings Division by the employer not later than three days after compliance with the notice requirements of this rule.

438-85-421 RESPONSE TO EMPLOYEE REQUESTS.

Upon written request from any affected employee, the Hearings Division shall give the employee:

(1) Reasonable notice of any hearing or other scheduled proceeding in the case,

(2) A copy of any withdrawal or settlement that is filed, and

(3) A copy of any Opinion and Order entered by a referee in deciding the case.

438-85-426 INTERVENTION.

(1) A petition to intervene in a contested case may be filed by a person at any time before the case is closed without a hearing, or before any scheduled hearing starts.

(2) The petition must state the petitioner's interest in the case, show that participation will assist in the determination of the issues, and explain why intervention will not necessarily delay the proceedings.

(3) The referee may grant a petition for intervention to such extent and upon such terms as considered appropriate.

(4) When a petition for intervention is granted, the intervenor becomes a party to the case.

438-85-431 REPRESENTATIVES OF PARTIES.

(1) Any party may act through a representative and may appear in a hearing by representative.

(2) A representative is not required to be an attorney at law or have any other special qualification.

(3) Unless a party is represented by an attorney at law, a designation of the party's representative must be in writing, contain the name, address and telephone number of the representative and be signed by the party. If the party is a corporation, the designation must be signed by an officer; if a partnership, by one of the partners; and if a public body, labor union, or other organization, by an official with the authority to designate a representative.

(4) A representative shall be considered to fully control the interests of the party in the case.

(5) A representative may terminate its status as a representative by filing a written notice thereof and serving a copy on all other parties.

438-85-436 ACCESS TO DOCUMENTS.

(1) The employer who is required to provide the Notice to Employees, in accordance with rule 85-416, must maintain, until the case is closed, copies of all documents filed in the case at a location convenient for affected employees to inspect and copy them at reasonable times.

(2) Any person may, at the offices of the Hearings Division, inspect and copy the documents filed in a contested case. Copies of documents may be ordered by mail. The cost of copies shall be at the rates set by the Board for the reproduction of its public records, but a nominal number of copies may be provided without charge.

CAPTIONS; FORM OF DOCUMENTS; PLEADINGS; AMENDMENTS; SERVICE

438-85-506 CAPTIONS OF CASES.

Contested cases shall be captioned by the Hearings Division and referred to by the following titles:

(1) A case initiated by a contested APD citation, notice of penalty or correction order shall be titled, "Accident Prevention Division, Plaintiff v. (name of appealing party), Defendant".

(2) A contested case that originated with an application for modification of a correction order or with an application relating to a variance shall be entitled, "(name of appealing party), Petitioner v. Accident Prevention Division, Respondent".

438-85-511 FORM OF DOCUMENTS.

(1) All documents, other than exhibits, filed after

the Hearings Division issues the Notice of Employees shall:

(a) Contain the case title and docket number assigned by the Hearings Division;

(b) Be typewritten on one side only of letter-size paper (8-1/2" by 11"), with at least a one-inch top margin;

(c) Contain the name, address and telephone number of the party or representative submitting the document; and

(d) Be signed by the party or representative submitting the document.

(2) The referee may refuse to accept any document that does not comply with this rule.

438-85-516 PLEADINGS.

Formal pleadings are not required. The pleadings in contested cases are as follows:

(1) In a case of the type described in subsection (1) of rule 85-506, APD's contested citation, notice of penalty or correction order is considered to be the "complaint" and the appeal is considered to be the "answer".

(2) In a case of the type described in subsection (2) of rule 85-506:

(a) If the appealing party was the original applicant, the application is considered to be the "petition", APD's contested notice or order the "response", and the appeal the "reply"; or

(b) If the appealing party was not the original applicant, the appeal is considered to be the "petition", and APD shall be presumed to have denied the appeal.

438-85-526 AMENDMENTS AS A RIGHT.

(1) At any time before a Notice of Hearing is issued, a party may, as a matter of right, once amend that party's pleadings to clarify the issues in the case and the grounds for the party's position.

(2) An amendment made by APD under this rule may not allege a new violation or increase a penalty.

(3) Amendments made in accordance with this rule are effective upon filing.

438-85-531 CORRECTION OF DEFECTIVE APPEAL.

If an appeal fails to specify the matters contested and the grounds for the appeal, or otherwise fails to substantially comply with the requirements of rule 85-111, the referee may, on the referee's own motion or upon motion of a party, order the appealing party to correct the defects by filing an amended appeal, or a supplement to the appeal, within such time as the referee considers reasonable. If within the time permitted the appealing party fails to amend or supplement the appeal to conform with rule 85-111, the appeal may be dismissed by the referee.

438-85-536 AMENDMENTS UPON MOTION.

At any time, upon motion of a party made in accordance with rule 85-735, the referee may allow a pleading to be amended for good cause shown and upon such terms as the referee considers proper to protect the interests of the parties and affected employees.

438-85-541 SERVICE OF DOCUMENTS ON OTHER PARTIES.

(1) At the time a party files any document with the Hearings Division, the party shall serve a copy of that document on every other party to the case.

(2) Service shall be made upon a party by first class mail or by personal delivery, and is effected at the time of mailing or personal delivery.

(3) Service upon a party who is acting through a representative shall be made upon that representative.

438-85-545 PROOF OF SERVICE.

(1) A party who files a document with the Hearings Division shall include with the document a proof of service which states the date and manner of compliance with rule 85-541, including the address at which the other party was served.

(2) Proof of service may be made by:

(a) Affidavit of service;

(b) Written statement made upon the document filed, and signed by the party or representative making the statement; or

(c) Letter of transmittal.

438-85-550 EX PARTE COMMUNICATIONS.

(1) There shall be no ex parte communication, concerning the merits of any pending case, between any employee of the Board and any of the parties, their representatives or their employees.

(2) In the event an ex parte communication occurs, the Presiding Referee or the referee presiding at the hearing shall place on the record a statement of the substance of any written or oral ex parte communication on a fact in issue made to the referee during the pendency of the proceedings and notify the parties of the communication and of their right to rebut such communication and may enter such orders or take such action as fairness requires. The Board will take appropriate disciplinary action against any employee of the Board who knowingly solicits or makes a prohibited ex parte communication.

438-85-606 WITHDRAWAL OF APPEAL.

(1) The appealing party may file a written withdrawal of his appeal at any time before the referee issues an Opinion and Order.

(2) When an appeal is withdrawn, provided that a third party has not entered an appearance, the referee shall issue an order dismissing the appeal, affirming the contested APD citation, notice or order, and closing the case. The referee's order shall advise the appealing party of the effect of any stay of a correction order that has occurred or been granted pursuant to rule 85-326.

(3) If the contested APD citation, notice or order was amended after the appeal was filed, an order affirming the amended citation, notice or order and closing the case shall not be issued until after the Notice to Employees required by rule 85-416 has been posted or otherwise given to affected employees.

438-85-611 WITHDRAWAL BY THIRD PARTY.

(1) A third party in a contested case may file a written withdrawal at any time before the referee issues an Opinion and Order.

(2) A withdrawal by a third party shall be effective at the time of the filing.

438-85-616 WITHDRAWAL BY APD.

(1) APD may move to withdraw its contested citation, notice or order at any time before the referee issues an Opinion and Order.

(2) The referee shall grant an APD motion to withdraw and shall issue an order vacating the contested APD citation,

notice or order and closing the case, without further proceedings, provided that:

(a) No third party has entered an appearance in the case, and

(b) The Notice to Employees required by rules 85-416 has been posted or otherwise given to affected employees.

(3) The APD citation, notice or order shall be vacated with prejudice if the motion to withdraw it is filed more than 20 days after APD is notified of the appeal.

438-85-621 SETTLEMENT.

(1) A settlement is not effective until it is approved by an order of the referee.

(2) The parties may file a settlement at any time before the referee issues an Opinion and Order.

(3) When a settlement is filed, the referee shall issue an order approving the settlement and closing the case, without further proceedings, provided that the Notice to Employees required by rule 85-416 has been posted or otherwise given to affected employees.

438-85-626 ABANDONMENT.

(1) If, within such reasonable time as may be allowed in a written request from the Hearings Division, a party fails to file a report designating the party's unavailable dates for a hearing, the referee may order the party to show cause why the party should not be considered to have abandoned the party's pleading and withdrawn from participation in the case.

(2) If a party fails to show cause as ordered under subsection (1) of this rule, within the time stated in the order, the referee may enter an appropriate dismissal order.

438-85-631 FAILURE TO FILE DOCUMENT.

If a party fails to file any document when due, the referee may, in the referee's discretion:

(1) Treat the failure as a waiver of the party's right to file the document, and presume that the document, if filed, would be adverse to the party's position on any issue related to it;

(2) For good cause, treat the failure as a waiver of the party's right to further participation in the proceedings.

438-85-636 REOPENING OF CLOSED CASE BY PARTIES.

(1) A case that has been closed as the result of a settlement or withdrawal shall be reopened by the Hearings Division upon the filing of:

(a) A written application joined in by all parties to the case and filed within 20 days after the case was closed; or

(b) Any party's written application, supported by an affidavit showing that the withdrawal or settlement resulted from material misrepresentations made knowingly by another party, filed within 20 days after the party first received knowledge of the facts on which the application is based.

(2) In a case reopened under this rule, the Hearings Division shall, at the request of a party, schedule a hearing before a referee to determine whether or not the settlement or withdrawal should be vacated.

438-85-641 EMPLOYEE OBJECTION TO CLOSED CASE.

(1) A case that has been closed as the result of a settlement or an APD withdrawal shall be reopened if an affected employee files a timely objection to the settlement or withdrawal on the ground that.

(a) No notice of the contested case was provided to affected employees as required by rule 85-416; or

(b) APD's settlement or withdrawal was unlawful, capricious or an abuse of discretion; or

(c) APD's settlement or withdrawal was the result of material misrepresentations made knowingly by the appealing party.

(2) An employee objection to a settlement or withdrawal is timely if it is filed within 20 days after the employee first received knowledge of the facts upon which the objection is based.

(3) In a case reopened under this rule, the Hearings Division shall, at the request of a party or the objecting employee, schedule a hearing before a referee to determine whether or not the settlement or withdrawal should be vacated.

PRE-HEARING PROCEDURES

438-85-705 DECISION BY REFEREE WITHOUT HEARING.

(1) To reduce the cost to the public, to the parties and to their witnesses, the Board encourages the parties to submit their cause to the referee, wherever possible, without a hearing.

(2) A case may be decided by the referee without a hearing upon the joint agreement of all parties, and upon the parties' written submission of the following:

(a) A joint statement of all issues to be decided;

(b) Stipulations as to all relevant and necessary facts about which there is no dispute;

(c) Affidavits, depositions, interrogatories or exhibits to establish facts which are in dispute; and

(d) Written arguments on each party's contentions.

438-85-710 SETTING & NOTICE OF HEARING.

(1) A hearing shall not be scheduled, except for good cause, until:

(a) The Notice to Employees required by rule 85-416 has been posted or otherwise given to affected employees, and

(b) Each party has either designated a representative or advised that the party will act in the party's own behalf.

(2) Notice of a scheduled hearing shall be given to all parties by the Hearings Division at least 20 days before the hearing date, unless the parties agree to a shorter period of notice.

(3) The notice of a hearing shall include the date, time and place of hearing.

438-85-715 PLACE OF HEARING.

The hearing shall be held in Oregon at a place that is reasonably convenient for the appealing party and affected employees, or at such other place as may be selected by the referee.

438-85-720 POSTPONEMENT OR CONTINUANCE OF HEARING.

(1) The referee may postpone or continue a hearing to another time or place on the referee's own motion, or at the request of any party upon a showing of good cause.

(2) A party's request for postponement or continuance must be made promptly after receipt of the Notice of Hearing, or as soon thereafter as the facts requiring the delay become known. The reasons for a postponement or continuance must be included in the request. Oral requests must be confirmed in writing.

(3) The party requesting a postponement shall, where

practicable, determine whether the other party objects to the delay, and so advise the referee in the request for postponement.

(4) The referee shall, in determining whether there is good cause for a postponement or continuance, take the following into consideration:

(a) Delays are inconsistent with the Board policy that appeal proceedings be prompt.

(b) A party who has furnished unavailable dates for a hearing is presumed to have thoroughly evaluated the party's case and to be fully prepared to proceed.

(c) Parties are expected to submit for decision all matters in controversy at a single hearing and to produce at that hearing all necessary evidence, including witnesses, documents and all other matters considered essential in the proof of allegations or defenses.

438-85-725 JOINT STATEMENT OF ISSUES; PRE-HEARING CONFERENCE.

At any time before hearing the referee may order the parties to:

(1) Jointly prepare and submit a written statement setting forth the relevant facts about which there is no dispute, each party's contentions of fact, and the issues of fact and law to be decided by the referee.

(2) Exchange information or attend a pre-hearing conference with the referee for the purpose of simplifying and clarifying the issues or expediting the proceeding.

438-85-730 CONSOLIDATION OR SEPARATION.

If no substantial right of any party will be prejudiced, the referee may, for good cause:

(1) Consolidate cases in which there are common parties and common questions of law or fact; or

(2) Divide the issues of a case into separate cases.

438-85-735 MOTIONS.

(1) All motions that can be made before hearing shall be filed with the referee no later than 15 days before the hearing date except for good cause shown.

(2) Pre-hearing motions shall be in writing and contain a clear and plain statement of the relief sought and the grounds for relief.

(3) Any party on whom a pre-hearing motion is served shall have ten days, or such greater time as the referee may allow, to file response to the motion.

(4) Arguments on pre-hearing motions shall be in writing, except in the discretion of the referee.

438-85-740 DISCOVERY METHODS.

(1) On petition of any party to a contested case, depositions, depositions upon oral examination (ORCP 39) or written questions (ORCP 40), and production of documents or things (ORCP 43), may be taken and used in the same manner and to the same extent as provided by law in civil actions, except as herein stated.

(2) The referee shall make determinations and issue orders in the manner required by the court by ORCP 36C, except that attorney fees shall not be allowed.

(3) The petition shall set forth:

(a) the name and address of the witness whose testimony is desired;

(b) a showing of the materiality of the testimony;

(c) a request for an order that the testimony of the witness be taken before an officer named in the petition for that purpose. The formality of the petition may be waived between the parties.

(4) A reporter's fee for a deposition shall be taken

by the party at whose instance the deposition is taken, unless otherwise agreed by the parties or directed by the referee.

(5) If any person fails to comply with a subpoena, or any party or witness refuses to testify on any matters on which the party or witness may be lawfully questioned, proceedings to compel obedience may be instituted in accordance with ORS 654.130 or ORS 183.440.

438-85-745 SUBPOENAS.

(1) The attendance and testimony of witnesses at the hearing, or the production of documentary or physical evidence under the witnesses' control or possession, may be compelled by subpoena.

(2) Subpoenas may be issued by the Presiding Referee, the referee, or the representative of record of the party in whose behalf the witnesses are required to appear. The Hearings Division shall provide subpoenas in blank, upon request, to a party or the party's representative of record.

(3) Any person present at the hearing may be required to testify to the same extent as if the person had been subpoenaed.

(4) If any person fails to comply with a subpoena, or any party or witness refuses to testify on any matters on which such party or witness may be lawfully questioned, proceedings to compel obedience may be instituted in accordance with ORS 654.30 or ORS 183.440.

(5) Witnesses appearing by subpoena shall be paid, by the party who subpoenas them, the same fees and mileage as required by law for witnesses in civil actions. Parties and employees of APD shall not receive such witness fees or mileage.

438-85-750 CHANGE OF REFEREE.

(1) A referee may withdraw from a case whenever he or she considers himself or herself disqualified.

(2) Any party may request that the referee be removed from a case, on the 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.

(3) 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 allegation in the affidavit.

(4) If the Presiding Referee does not disqualify the referee, the Presiding Referee shall so rule on the record, stating the grounds for the ruling, and the case shall proceed with the referee.

438-85-755 EXTENSIONS OF TIME.

Requests for extensions of time for filing of any documents should be received in advance of the day on which the document is due to be filed.

HEARINGS

438-85-800 SPECIAL CIRCUMSTANCES; WAIVER OF RULES.

In special circumstances not contemplated by the provisions of these rules, or for good cause shown, the referee may, upon application by any party or intervenor, or on the referee's own motion, after ten (10) days notice to all parties and intervenors, waive any rule or make such order as justice or the administration of the Act requires. This rule shall not apply to OAR 438-85-121(1).

438-85-805 DUTIES AND POWERS OF REFEREE.

It is the duty of the referee to conduct a fair and impartial hearing and avoid delay. The referee has the authority to:

(1) Issue subpoenas;

(2) Order depositions to be taken;

(3) Hold conferences for settlement of the case or simplification of the issues;

(4) Dispose of procedural requests, motions or similar matters;

(5) Administer oaths and affirmations;

(6) Rule upon offers of evidence;

(7) Regulate the course of the hearing and, if necessary, exclude persons from the hearing;

(8) Require a party to state the party's position on any issue in the case and the legal basis for that position;

(9) Order a party to produce a witness or other evidence;

(10) Call and examine any party or witness;

(11) Close the hearing record, or reopen it, as the needs of justice and the hearing require;

(12) Take any other action necessary for a full and fair disposition of the case.

438-85-810 FAILURE TO APPEAR.

(1) Failure of a party to appear at the hearing may be considered a default and a waiver of all rights except the right to be served with a copy of the referee's decision and the right to request judicial review in accordance with ORS 183.480 to 183.500.

(2) Upon a showing of good cause, the referee may excuse a party's failure to appear and reconvene the hearing.

438-85-815 RECORD AND TRANSCRIPT OF HEARING.

(1) A verbatim record shall be made of the hearing, including all motions, rulings and testimony. Reporters' hearing and transcript fees shall be paid by the Board, except as provided in subsection (3) of this rule.

(2) At any time before the referee's decision becomes final, the referee may order a full or partial transcript of the hearing record.

(3) At any time before the reporter's notes or recordings of the hearing are destroyed, any person may order a transcript at that person's expense.

(4) When the record of a case is forwarded to the Court of Appeals for judicial review pursuant to ORS 183.482(4), each party shall be served with a copy of the record, excepting exhibits.

(5) Reporters' notes or records of a hearing may be destroyed six months after final disposition of the case by the referee or court.

438-85-820 BURDEN OF PROOF.

(1) APD has the burden of proving:

(a) A denied violation.

(b) The reasonableness of a contested penalty.

(c) The reasonableness of a contested correction order.

(2) The party who contests APD's grant or denial of a requested modification of the time for correction of a violation has the burden of proving that APD's decision is unreasonable.

(3) The party who contests a proposed, APD order that will grant, deny, modify or revoke a variance has the burden of proving that the proposed order is unreasonable.

(4) The party having the burden of proving a fact must establish it by a preponderance of the evidence.

438-85-825 CONDUCT OF HEARING.

(1) Testimony shall be taken only on oath or affirmation.

(2) Each party shall have these rights;

(a) To call and examine parties and witnesses;

(b) To introduce exhibits;

(c) To question the witnesses of other parties on any matter relevant to the issues even though that matter was not covered in the direct examinations;

(d) To impeach any witness regardless of which party first called the witness to testify; and

(e) To rebut the evidence against the party.

(3) The taking of evidence in the hearing shall be controlled by the referee in the manner best suited to ascertain the facts and safeguard the rights of the parties.

(4) The hearing shall be conducted in the English language. Upon reasonable advance request, a qualified interpreter shall be provided in accordance with ORS 183.418.

438-85-830 AFFIDAVITS.

An affidavit may be admitted in lieu of oral testimony if the matters contained in the affidavit are otherwise admissible and no other party objects to the admission of the affidavit.

438-85-835 EXCLUSION OF WITNESS FROM HEARING ROOM.

At the request of a party, the referee may exclude from the hearing room an adverse party's witness not at the time under examination, so that the excluded witness will not hear the testimony of other witnesses, but a party or his representative shall not be excluded.

438-85-840 RULE OF EVIDENCE.

(1) Evidence that reasonably prudent persons commonly rely upon in the conduct of their serious affairs shall be admissible.

(2) Irrelevant, immaterial or unduly repetitious evidence shall be excluded.

(3) The rules of privilege recognized by law shall be followed.

438-85-845 OFFICIAL NOTICE.

(1) The referee may take notice of judicially cognizable facts and the referee may take official notice of general, technical or scientific facts within the referee's specialized knowledge.

(2) The referee shall advise the parties of, and give them an opportunity to contest, any facts or other matters of which official notice is being taken.

(3) APD shall offer as an exhibit at the hearing a copy of each Division of the Oregon Occupational Safety and Health Code that contains rules upon which APD intends to rely. The exhibit shall include a certification by the Director or the Director's designee, or by the Secretary of State, that the applicable rules set forth in the exhibit are true copies of Oregon Administrative Rules adopted by the Director, filed with the Secretary of State, and in effect on the dates relevant to the issues in the case.

438-85-850 OBJECTIONS.

(1) Any objections to the introduction of evidence or to the conduct of the hearing shall be accompanied by a brief statement of the grounds for the objection.

(2) It is not necessary for a party to take an "exception" to an adverse ruling on an objection in order to

preserve the question for judicial review.

(3) Whenever the referee excludes the testimony of a witness, the party adversely affected may make an offer of proof on the record for the purpose of judicial review.

438-85-855 EXHIBITS.

(1) Exhibits, where practicable, shall be on one side only of paper 8-1/2" by 11" in size or folded in multiples thereof.

(2) The party offering an exhibit shall provide a copy of it to each of the other parties, unless the referee finds it impractical. Wherever possible, unless the exhibit is to be used solely for impeachment, such copies shall be provided to the other parties before the hearing commences.

(3) All offered exhibits, whether or not admitted into evidence, shall be a part of the record in the case.

(4) Unless the referee determines that exceptional circumstances require that an object or real evidence accompany the record, an accurate description or photograph of the object shall be substituted for it. The party offering such evidence shall be responsible for providing the description or photograph, and for retaining custody of the object until the case is closed.

438-85-860 VIEW OF PREMISES.

On motion of any party or on the referee's own motion, the referee may, prior to the hearing or during a recess of the hearing for that purpose, view the premises, equipment or processes related to an issue in the case, in order to obtain a better understanding of the testimony. All parties shall be given reasonable notice of, and an opportunity to be present during, a viewing. The referee shall not consider as evidence in the case the impressions he obtains from a viewing.

438-85-865 OPINION & ORDER OF REFEREE.

(1) The decision of the referee in a contested case shall be rendered in a written Opinion and Order, which shall also contain findings of fact and conclusions of law.

(2) Except for matters stipulated to by the parties or officially noticed by the referee, no factual information or evidence that is not made part of the record shall be considered by the referee in making determinations.

(3) A default order may be issued only upon a prima facie case made in the evidentiary record.

(4) The Opinion and Order of the referee shall be deemed to be a final order of the Board.

(5) Each party or, if applicable, a party's representative shall be mailed or delivered a copy of the referee's Opinion and Order, with notice of the party's right to judicial review by the Court of Appeals as provided in ORS 183.480 to 183.500.

438-85-870 RECONSIDERATION.

(1) The referee may withdraw an Opinion and Order for the purpose of reconsideration at any time prior to:

(a) The expiration of the period allowed for filing a petition for judicial review, if one has not been filed; or

(b) The date set for oral argument before the Court of Appeals on a petition for judicial review, as permitted by subsection (6) of ORS 183.482.

(2) Reconsideration may be upon the referee's own motion, or upon motion of a party showing error, omission, or misconstruction of a statute or rule.

(3) Written notice of reconsideration shall be given by the referee to all parties.

(4) The referee may affirm, modify or reverse an Opinion and Order that has been withdrawn.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Francisca A. Duran, Claimant.

DURAN,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB Nos. 85-03909, 85-06267; CA A41266)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 4, 1987.

Bruce D. Smith, Salem, argued the cause for petitioner. On the brief were Sharon Stevens, and Law Offices of Michael B. Dye, Salem.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded with instructions to allow the claim.

ROSSMAN, J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's determination that she did not suffer a compensable mental disorder caused by stress associated with her employment. On *de novo* review, we reverse.

Claimant is employed as a counselor by the Salem Housing Authority. On January 28, 1985, she slipped on ice in the Housing Authority's parking lot and sustained a compensable injury to her right hip and left wrist. About the same time, she became involved in a dispute with her immediate supervisor over vacation time. The dispute arose when claimant requested vacation leave for the same dates that two other employes had signed up for earlier. Her supervisor told her that, if she wanted to take the leave as requested, she would have to exercise her seniority rights. Claimant said that she was reluctant to do so and later expressed surprise and dismay when, without further discussion, the supervisor announced at a weekly staff meeting that claimant had invoked seniority. Claimant subsequently filed a grievance regarding that matter.

After claimant filed the grievance, she perceived a change in her supervisor's attitude and, because of two events in particular, concluded that she was being harassed in retalia-

tion for filing the grievance and was being discriminated against because of her race. Initially, she felt harassed and discriminated against when her supervisor made pointed inquiries and contacted her doctor concerning work restrictions placed on her because of her hip injury. Then the event occurred which, for claimant, was the last straw. She was called into her supervisor's office and informed that she had been assigned temporarily to a new position that both she and her coworkers considered less desirable and more stressful than her former position. Claimant also considered the assignment demeaning and believed that she had been selected unfairly over employes with less seniority.

After being informed of her new job assignment, claimant became distraught and, later that afternoon, filed the workers' compensation claim that precipitated this proceeding, indicating that she was unable to work because of

"stress due to on-the-job harassment."[1] SAIF, her employer's insurer, denied the claim, and claimant asked for a hearing. The referee found that claimant did suffer a stress-related mental disorder and that the major contributing cause was job-related stress. He denied the claim, however, after concluding that she had not been harassed or discriminated against and that the real events underlying her perception that she had been, when viewed objectively, "were not actual stressful circumstances."

The Board affirmed the referee's decision, but for different reasons. It found that claimant did experience "real events and conditions while performing her work activities which, when viewed objectively, were capable of producing stress." Nevertheless, it concluded that claimant's mental disorder was not compensable, because "most of her stress" is the result of her perception that she was being subjected to harassment, which, although "honest," was "unfounded." The Board also stated that it was not persuaded that claimant's job-related stress was the major contributing cause of her mental disorder[2] and questioned whether she is suffering from such a condition at all.

A "stress claim" is compensable if the claimant establishes that she has suffered a mental disorder, the major contributing cause of which is her reaction to real on-the-job events or conditions. *McGarrah v. SAIF*, 296 Or 145, 675 P2d 159 (1983). Here, we find, as did the referee, that claimant suffered a mental disorder and that the major contributing cause is job-related stress. That finding is consistent with the opinions of both Dr. Brust, claimant's treating physician, and Lowther, the clinical social worker to whom she was referred for treatment.

As in *Petersen v. SAIF*, 78 Or App 167, 714 P2d 1108, *rev den* 301 Or 193 (1986), in which the claimant filed a claim indicating that she was unable to work because of "stress, job harassment and undermining of the city administrator," we

[1] Because we hold that claimant's mental condition is compensable on the basis of on-the-job stressful events, we do not consider her claim that her mental condition is causally related to the compensable physical injuries that she sustained earlier.

[2] Claimant was also subjected to a number of off-the-job stresses, including the death of her parents and marital problems. We agree with the referee that the major contributing cause of claimant's mental disorder was job-related stress.

need not decide whether claimant was, in fact, subjected to harassment. In *Petersen*, we held that, if the claimant reacted to real events, she had a basis for a stress claim regardless of whether her perception of harassment was reasonable or rational. The issue is whether the events underlying claimant's perception of harassment and discrimination are real, as opposed to imaginary, and are capable of producing stress; their medical effect on a claimant, however, is measured by the actual reaction, rather than by an objective standard of whether the conditions would have caused disability of an average worker. *Petersen v. SAIF, supra,* 78 Or App at 170.

Claimant's perception that she was being harassed, whether or not it was unreasonable, was based on real events which were capable of causing stress. *See Leary v. Pacific Northwest Bell,* 67 Or App 766, 680 P2d 5 (1984).[3] Accordingly, we hold that her claim is compensable. SAIF argues that any on-the-job stress was solely caused by claimant's perception that she was being harassed and not by the events underlying her perception. That argument begs the question. The fact is that real, stressful events did occur which caused claimant to suffer a mental disorder.[4]

Reversed and remanded with instructions to allow the claim.

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[3] In *Leary*, we found that most of the events and conditions of the claimant's employment that were claimed to have produced stress were only imagined and, in fact, did not exist. 67 Or App at 770.

[4] Claimant seeks the imposition of a penalty and attorney fees under ORS 656.262(10) for denial of her claim. Although SAIF's denial was wrong, we conclude that SAIF did not act so unreasonably as to justify the assessment of a penalty. *See Petersen v. SAIF, supra,* 78 Or App at 172.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Cathie R. Judd, Claimant.

JUDD,
Petitioner,

v.

PENDLETON WOOLEN MILLS,
Respondent.

(WCB 85-05063; CA A41994)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 6, 1987.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were Delbert J. Brenneman and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; referee's order reinstated.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee's determination that she was entitled to medical benefits for nondisabling back pain.

Claimant worked as a spooler for Pendleton Woolen Mills from 1966 to 1974 and from 1977 to the present. On February 13, 1985, she attempted to move a yarn basket weighing 600 pounds and immediately thereafter experienced mid- to low back pain. A few days later, because the pain had persisted, she went to see Dr. Scott, a chiropractor. Under his supervision, she wore a back brace for two weeks and underwent manipulations several times a week. She did not, however, miss time from work. In Scott's opinion, claimant was suffering from acute lumbrosacral sprain or strain, sciatica, thoracic sprain or strain and subluxation of the thoracic vertebrae. He stated in a report on May 31, 1985, that "in all probability" her condition was attributable to her 1985 injury.

Employer requested an examination by Dr. Howell, who had previously treated claimant over a two-month period in 1981 for a work-related back strain. In his report, Howell stated that claimant's recovery from the 1981 strain had been delayed due to a somatization disorder. In his view, muscle strain is characterized by specific physical abnormalities, such as areas of spasm and motion restriction. In examining claimant, he found no motion restriction. He did note a muscle spasm in the second thoracic segment, which produced no pain when compressed and was distant from the area of reported pain. He also noted muscle spasms in the cervical area "not thought to represent the presence of a pathological condition and not thought to be related to [claimant's] occupational activity at Pendleton Woolen Mills or the described incident."

Howell stated that claimant's condition was medically stationary with regard to the effects of her occupational activity. He concluded that "the possibility of psychological factors playing a significant role, as were identified during her 1981 low back complaints, could not be excluded and are considered to be a moderate possibility." Howell disputed Scott's diagnoses and testified that to conclude reasonably that claimant had suffered an injury in February, 1985, would

require the identification of objective physical abnormalities. He testified on cross-examination that it is possible that claimant had had physical abnormalities which had resolved between the time of the incident and his examination two months later, but that in that case he would also have expected a significant reduction in symptoms.

We do not find either medical opinion persuasive. Scott did not explain or state whether his diagnosis was based on objective findings. Howell, on the other hand, emphasized the need for objective findings but treated muscle spasms as

inconsequential. He noted a "moderate possibility" that psychological factors play a role in claimant's present symptoms, but he did not deny that claimant had experienced pain from her activities on the job. He implicitly acknowledged that there was an "incident" on February 13, 1985, when he reported that he considered her condition to be medically stationary "with regard to the effects of her occupational activity."

The referee stated that claimant was a credible witness. She testified that, although she had experienced back pain in the past, it had resolved by 1982. She testified that her present back pain was the immediate consequence of the February, 1985, incident. Even if, as Howell suggests, the continuation of her symptoms is psychosomatic, that does not defeat compensability. *Barrett v. Coast Range Plywood,* 294 Or 641, 661 P2d 926 (1983). We conclude that claimant's undisputed evidence regarding the onset of pain after the February, 1985, incident is sufficient to make her claim compensable. *See Davis v. SAIF,* 63 Or App 245, 662 P2d 803 (1983).

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David D. Grimes, Claimant.

GRIMES,
Petitioner,
v.
SAIF CORPORATION et al,
Respondents.

(WCB 85-00302; CA A41877)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 2, 1987.

Charles E. Lundeen, Portland, argued the cause for petitioner. With him on the brief was William H. Skalak & Associates, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed; remanded to the Board for determination of compensability.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order reversing a referee's order which held that his claim was timely filed and compensable. The Board held that

the claim was not timely under ORS 656.265(4) and, therefore, did not reach the issue of compensability. On *de novo* review, we reverse and remand.

In August, 1984, claimant was injured at a construction site when the structural steel he was standing on suddenly dropped six to twelve inches and he received a strong jolt. He described the impact as follows: "[I]t felt like I pulled a muscle in my neck." He did not report the event and did not seek medical treatment at that time. About two weeks later,[1] when his symptoms had not subsided, he went to his doctor at Kaiser Permanente on August 16. The initial diagnosis was muscle strain in the neck and shoulder with spasms. Although his neck remained stiff, he continued to work. Fletcher, claimant's co-worker, testified that claimant could hardly move his neck and walked around "like a robot."

Claimant's symptoms gradually worsened during the fall of 1984. On November 26, he returned to Kaiser and was diagnosed as having chronic cervical strain. On November 29, he sought treatment at Western States Chiropractic College. By that time, he had also developed numbness in his right thumb and palm and pain in his right arm. On December 3, he returned to Kaiser. Dr. Tahir, a neurosurgeon, suspected cervical disc involvement and performed a myelogram and diagnosed a herniated disc. On December 11, Tahir performed a cervical hemilaminectomy and discectomy.

On December 6, claimant called employer and reported that he was undergoing medical treatment for a neck injury that had occurred on the job in August. On December 12, he filed a claim. Employer signed the 801 form on December 18. SAIF denied the claim on December 28.

Claimant requested a hearing. He testified that he did not report the injury to his supervisor, because he felt that it was relatively minor and because he had medical coverage through the carpenter's union. He also testified that he feared

losing his job if he filed a claim, because his previous employer had told him that the industry as a whole looked down on anyone filing a compensation claim and that an employe might lose his job for filing. Claimant's supervisor reported that most employes do not file claims for minor scrapes and bruises.

The referee found claimant's testimony credible and also found Fletcher's testimony regarding claimant's inability to move his neck credible. He found that claimant had sustained a compensable injury in August, 1984, that employer was not prejudiced by the late filing and that claimant had good cause for filing late, because of his concern for keeping his job. The referee concluded that the claim was not time-barred.

The Board reversed, holding that the insurer was prejudiced by claimant's failure to file timely, because it was unable to investigate the accident scene and to conduct an independent medical examination to determine whether the surgery that had been performed was necessary. It also held that there was no conduct by employer that would have given

[1] Claimant did not remember the exact date of his injury.

claimant a reasonable basis to believe that his job would be in jeopardy and, therefore, that he did not have good cause for filing late.

ORS 656.265 provides, in relevant part:

> "(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 30 days after the accident. * * *
>
> "* * * * *
>
> "(4) Failure to give notice as required by this section bars a claim under ORS 656.001 to 656.794 unless:
>
> "(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice; or
>
> "* * * * *
>
> "(c) The notice is given within one year after the date of the accident and the worker or beneficiaries of the worker establish in a hearing that the worker had good cause for failure to give the notice within 30 days after the accident."

A claim made later than 30 days after an injury will not be held

to be untimely if there is no prejudice to the employer *or* if the claimant demonstrates good cause for late filing. *Baldwin v. Thatcher Construction,* 49 Or App 421, 619 P2d 682 (1980).

Claimant contends that the Board erred in concluding that employer was prejudiced. He argues that, even if he had filed within 30 days, employer would not have been able to investigate the accident scene, because the job site had been significantly altered during the 30 days after he was injured. He also argues that employer was able to contact Fletcher, the witness, and that no investigation was conducted until after he requested a hearing. Finally, he argues that all the medical information that SAIF needed was available to it and that, because he was suffering rapidly worsening symptoms, it was medically proper for the doctor to go ahead with the surgery.

An insurer or self-insured employer bears the burden of proving that there has been prejudice from an untimely filing. *Inkley v. Forest Fiber Products Co.,* 288 Or 337, 348, 605 P2d 1175 (1980); *Raifsnider v. Caveman Industries, Inc.,* 55 Or App 780, 639 P2d 1298 (1982). The passage of time is not itself sufficient to show prejudice; the employer must prove some actual prejudice. *Ford v. SAIF,* 71 Or App 825, 693 P2d 1339, *rev den* 299 Or 118 (1985). Further, to bar a claim, the prejudice must have occurred after the period of time in which a worker is statutorily entitled to file a claim. *McNett v. Roy-Ladd Const. Co.,* 46 Or App 601, 605, 613 P2d 47, *rev den* 289 Or 588 (1980).

We agree with claimant that employer was not prejudiced by its inability to investigate the accident scene. During the month of August, the area in which he was injured was encased in concrete. Thus, even if he had reported within the statutory 30-day period, employer could not have investigated the rebar on which he was standing at the time when he was injured. Claimant cannot be held responsible for changes that occurred within the period during which he was statutorily entitled to file a claim. Employer's inability to conduct an independent medical investigation to determine whether the

surgery was necessary has nothing to do with the *compensability* of the claim. Therefore employer was not prejudiced.

Reversed; remanded to the Board for determination of compensability.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Janell M. Sherman, Claimant.

SHERMAN,
Petitioner,

v.

WESTERN EMPLOYERS INSURANCE,
Respondents.

(WCB 85-04086; CA A41799)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 2, 1987.

Ronald L. Bohy, Salem, argued the cause and filed the brief for petitioner.

Craig A. Staples, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed; referee's order reinstated.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order that reversed the referee's order setting aside employer's denial of her claim. The Board held that claimant had not proven by a preponderance of the evidence that she had injured her back while at work. We review *de novo* and reverse.

Claimant, a registered nurse, testified that while at work on January 30, 1985, she felt a searing pain in her back when she twisted as she steadied an unstable patient, that her back continued to hurt and that she mentioned the incident later that day to Hotchkiss, her supervisor. She also testified that Hotchkiss called her at home the next evening to ask her to work the following day. She responded that she had back trouble but that she would work if someone else could be assigned to do the required lifting. She testified that she reminded Hotchkiss that she had injured her back at work the day before.

Claimant's sister, Teresa, testified that claimant appeared to suffer back pain when she returned from work January 30 and that she told her that she had hurt her back assisting a patient. Teresa also testified that she had answered

the telephone when Hotchkiss had called and that she overheard claimant remind Hotchkiss that she had been injured at work the day before.

Hotchkiss testified that claimant did not report any injury on January 30. She admitted that Teresa had answered the telephone when she called to ask claimant to work and that claimant had asked for help with lifting. However, she testified that claimant did not mention that she had injured herself at work the day before. Hotchkiss testified that she did assign someone to assist claimant with lifting the next day.

Claimant testified that she worked despite back pain on February 1, 2 and 4, when she began a two week period away from work, and that during that time she treated herself with bed rest, hoping that the injury would improve. Her condition did not improve, and on February 18 she saw Dr. Coleman and on February 20 Dr. Isaacson. Both doctors initially diagnosed bursitis and indicated "no trauma" in their notes. Claimant explained that she told Coleman that she had

earlier injured her back assisting a patient but that he had dismissed that incident as probably causing no more than a muscle spasm. She testified that Isaacson's nurse asked if she had fallen and injured her back and that she replied that she had not fallen.

After unsuccessful conservative treatment, Isaacson changed her diagnosis to a ruptured disc. She referred claimant to Dr. Misko, who confirmed the presence of the ruptured disc, and in early April he surgically removed it. Both Isaacson and Misko concluded that the twist to claimant's back on January 30 caused the disc to rupture.[1]

The referee found both claimant and Hotchkiss credible in their demeanor. He resolved the substantive conflict in their testimony by concluding that Hotchkiss had forgotten that claimant had told her that the back injury had occurred at work. The Board found that claimant did not inform Hotchkiss at the time of the alleged injury. It also found that it was unlikely that the injury to claimant's back occurred at work on January 30, because it found that the symptoms did not occur until two weeks later. Therefore, it concluded that claimant's injury was not compensable and reversed the referee's order awarding compensation.

In exercising *de novo* review, we generally defer to the referee's determination of credibility. However, when the issue of credibility concerns the substance of conflicting testimony, not just the demeanor of the witnesses, we make our own determination. *Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285, ___ P2d ___ (1987).

On March 6, 1985, Hotchkiss signed an 801 claim form. The portion to be signed by claimant indicated that the injury occurred in the course of employment on January 30, 1985.[2] The portion signed by Hotchkiss, as representative of employer, had stated that the date when employer first knew

[1] A nurse at the hospital stated in a deposition that Dr. Coleman had stated that claimant's injuries were caused by horseback riding. However, the only reference in Coleman's notes states "*no horseback* riding X 2 wk." (Emphasis in original.)

[2] On the copy of the form filed with the department, the check in the box indicating that the injury had occurred at work was scratched out and the "unknown" box was checked. No evidence in the record indicates how or why that happened, but it is uncontested that the *original* form indicated that the injury occurred at work.

of the injury was February 1, 1985, and that the injury occurred on the employer's premises. That information is consistent with claimant's testimony that she reported the injury shortly after it occurred.[3] It is also consistent with the uncontested fact that Hotchkiss did assign lifting help for claimant on February 1, 1985. We conclude that the injury occurred as claimant testified.

In reaching its conclusion that claimant's injury was not compensable, the Board also relied on the observation of Isaacson in a letter to employer's counsel that it was unusual for back strain symptoms to develop two weeks after a traumatic incident. The Board's reliance was misplaced. Isaacson's comments were general in nature and not addressed to claimant's situation in particular. Further, it is clear from the record that symptoms appeared *immediately* after the strain. It was the initial *diagnosis* which was not made until two weeks later, when claimant sought medical treatment. Finally, Isaacson's chart notes state that "[t]his [injury] occurred at work when she was trying to help support a patient who was falling. I suspect that it was at this time that the disc ruptured and the symptoms began."

Reversed; referee's order reinstated.

[3] Employer relies on testimony of other hospital employes that they did not know about claimant's injury, although claimant testified that she mentioned it to them. That testimony indicates that some witnesses *did* know that she was suffering back pain, but were not aware of the cause, and that some witnesses had not observed any difficulties, but admitted that they had limited contact with claimant because they were very busy.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jack W. Tucker, Claimant.

TUCKER,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY et al,
Respondents.

(WCB No. 81-09929; CA A40271)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 25, 1987.

Douglas A. Swanson, Portland, argued the cause and filed the brief for petitioner.

Allan M. Muir, Portland, argued the cause for respondents. With him on the brief were William H. Replogle and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed; referee's order reinstated.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee and held that claimant's bilateral foot condition was not compensable as an occupational disease. ORS 656.802. We reverse.

Claimant worked for employer as a pressman for approximately 12 years, beginning in 1969. As part of his job, he stood on a vibrating steel platform three to six hours each work day. In December, 1980, he began to experience problems with his feet and legs for the first time in his life. In September, 1981, his family doctor referred him to Dr. Neufeld, an orthopedic surgeon, who noted that claimant had painful feet and arches, for which he suggested arch supports. The supports, however, only partially and temporarily alleviated the painful condition. In January, 1982, claimant could not continue to work in the pressroom, because it was too painful to stand. He filed a claim.

Employer denied the claim, asserting that claimant had a preexisting condition—mildly deformed high arches or "pes cavus deformity"—which his employment had not worsened. The referee found that claimant's preexisting condition had worsened and allowed the claim. The Board reversed, concluding that only claimant's symptoms, and not his preexisting condition, had worsened. *See Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979).

The threshold question in this case is to identify the "occupational disease" from which claimant suffers, if any. Orthopaedic Consultants, to whom insurer referred claimant, diagnosed (1) bilateral moderately increased pes cavus deformity and (2) chronic foot strain. Dr. Tindall, a rheumatologist, to whom Neufeld referred claimant, reported:

> "Chief Complaint: Muscle Spasm. * * * Assessment: Leg and back pain which appears to be more of a mechanical problem with the patient having very loose ligaments in his left ankle and left knee allowing him to have an abnormal gait and exacerbating joint pain in these areas as well as his back."

She also wrote:

> "I suspect because of his foot structure that he has some structural problems with his feet and ankles that have allowed

> him to be susceptible to the type of problem which he is now having."

Neufeld wrote that claimant suffers from "painful feet" related to "mechanical stress." He diagnosed claimant's high arches as the source of the mechanical stress and pain and said that the structure of claimant's feet made him more susceptible. He wrote:

> "My basic diagnosis is that of bilateral cavus feet which have become painful. * * * The pain has been fairly consistently related to mechanical stess."

He also stated:

> "My opinion is that this is a developmental problem involving his cavus feet. It is my opinion that feet such as [claimant's]

are more subject to having difficulty from activities, etc., due to their configuration."

We find that claimant's occupational disease is chronic foot strain. The diagnoses of Tindall and Orthopaedic Consultants are not inconsistent with Neufeld's diagnosis, as they each describe the mechanical stresses that caused claimant's foot strain. The medical testimony shows that claimant's pes cavus deformity is not his occupational disease; it is a developmental structural problem. It made claimant more susceptible to the effect of standing in the pressroom on the steel platform for long hours.

The Board believed that claimant's occupational disease is the deformity itself. It relied on Neufeld's characterization of claimant's condition as a developmental "pes cavus deformity," which had not worsened, but had only become symptomatic. Neufeld wrote that "[claimant] has a job aggravated situation. This is an aggravation of a preexisting condition" and later concluded: "I do not have any objective evidence of worsening of the underlying cavus foot problem. It is the pain relating to that condition rather than any change in structure that has occurred." That conclusion, however, is not inconsistent with our understanding. He does not state that the shape of claimant's feet had changed; he has described a chronic painful experience, to which claimant's structural problems made him susceptible. We read Neufeld's references to an "aggravation of a preexisting condition" and to "symptoms" as consistent with Orthopaedic Consultants' identification of a chronic foot strain.

Moreover, claimant's work is the major contributing cause of his strain. *See* ORS 656.802. *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983). Neufeld stated on December 28, 1982, that claimant had a "job aggravated situation." On March 13, 1983, he wrote:

> "[Claimant's] feet have worsened during his employment as a pressman for the Oregonian * * *. I think one can say beyond reasonable doubt that the patient's increased time on his feet on his job has brought on his symptoms earlier than they would have if he would have had a sedentary-type of job sitting most of the time."

On May 17, 1983, Neufeld stated:

> "I think it is medically probable that his pain has been accelerated by his job and being on his feet. If he had not been on his feet on a continuing basis, I do not feel he would have had the severity of symptoms that he is having at the present time.
>
> "His worsened condition has not improved significantly since he has been off his job, and it appears that his condition is permanent in that he will not be able to go back to any type of job where he has to stand on his feet any length of time."

Tindall stated:

> "[Claimant's] work was a major cause of worsening of his disease."

Orthopaedic Consultants did not express an opinion on causation but stated that "working on a hard surface continuously was [not] advisable for this man." Claimant did not have problems with his feet until he had worked for years on the pressman's job.

This situation differs from an occupational disease where only the symptoms, not the underlying condition, have worsened or where the underlying condition has worsened, regardless of the job. *See Amfac, Inc. v. Ingram,* 72 Or App 168, 174, 694 P2d 1005, *rev den* 299 Or 37 (1985). There was no medical evidence that claimant's foot strain probably would have occurred if he had not stood for long hours on his job on a vibrating platform.[1]

Reversed; referee's order reinstated.

[1] Neufeld could only speculate that, "[i]f [claimant] had been at a job sitting most of the time, it *might have been* months or years before he developed problems." (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Vernon D. Kelso, Claimant.

KELSO,
Petitioner,

v.

CITY OF SALEM,
Respondent.

(83-10281; CA A38731)

Judicial review from Workers' Compensation Board.

Argued and submitted January 16, 1987.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Paul J. De Muniz, Salem, argued the cause for respondent. With him on the brief was Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded with instructions to accept claim.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board which affirmed the referee's denial of payment for medical expenses and an aggravation claim.[1] We reverse.

Claimant, a police officer, sustained a compensable injury to his right shoulder in 1979. He had two surgeries and, in 1982, was determined to have a permanent partial disability equal to 15 percent. On July 14, 1983, while making an arrest, his right shoulder froze for about 30 seconds. The following day he saw Dr. Gallagher, the physician who had previously

[1] Employer issued three denials from which claimant sought review. All involve the same issues.

treated him. The chart notes show that claimant had returned for the "same problem" but that Gallagher was not certain what was causing the problem and referred him to Dr. Schwarz for a neurological evaluation.

In July, Schwarz diagnosed amyotrophic lateral sclerosis (ALS), commonly known as "Lou Gehrig's disease." Claimant then went to Oregon Health Sciences Center where he saw Dr. Hammerstad, who referred him to Dr. Engel, a specialist in ALS at the University of California School of Medicine. Hammerstad's referral letter states that he could not make a determination whether or not claimant had ALS. After an examination, in February, 1984, Engel gave a diagnosis of possible ALS but said that the cause of the upper extremity paresthesias was undetermined. Engel explained the diagnosis in a follow-up letter to claimant:

> "The abnormality of sensation in your right upper extremity is not part of ALS. We did the myelogram and could not find a cause for that. Therefore it remains unexplained. Whether it is in some way due to the shoulder injury remains possible but uncertain at this time."

Claimant was also seen by Dr. Tiley, an orthopedic surgeon. In his initial analysis of the case, Tiley, relying on Schwarz' opinion that claimant had ALS, concluded that the impairment of the right shoulder was one of atrophy of musculature most likely caused by ALS. After reviewing results of the consultation by Engel, Tiley changed his opinion. He noted that the "experts in ALS * * * discount that any of the shoulder problem is related to [claimant's] neurologic process"

and concluded that the shoulder problem was mechanical. At the hearing, the referee concluded that claimant had not met his burden, because Tiley was not knowledgeable regarding claimant's condition in 1982 and because his premises were disputed by Schwarz, who was "more persuasive" about ALS. The Board affirmed. On *de novo* review, we disagree.

The medical evidence is conflicting and somewhat difficult to evaluate. Gallagher, who treated claimant for his previous injury, noted initially that he had returned for the "same problem," but he was unsure what was causing the problem and referred him to a neurologist. Gallagher expressed a willingness to defer to the experts on ALS,[2] but he did testify at the hearing that the shoulder problems were not related to the earlier injury. Hammerstad made a diagnosis of possible ALS. Schwarz diagnosed claimant's shoulder problem as ALS. However, the conclusion of Engel, a recognized expert, that claimant's shoulder problem was not related to ALS, was in direct conflict with Schwarz's opinion. After reviewing Engel's report, Tiley concluded that the current shoulder problems were attributable to claimant's injury and surgeries.

We conclude that claimant's shoulder problems were related to his injury. The opinions of Engel and Tiley are the most persuasive. Respondent argues that Tiley's conclusions were not reliable, because he changed his opinion. There was a reasonable explanation for changing his opinion. His initial

[2] In January, 1984, Dr. Gallagher stated in a chart note:

> "I have told [claimant] that if the ALS experts are willing to say that there are two separate problems and one of the problems is related to his shoulder and previous surgery and injury, then I would also be willing to say that."

conclusion that the shoulder disability was related to ALS was based in significant part on his deference to the ALS experts. He did not have Engel's report when he gave his initial opinion. After reviewing that report, which concluded that claimant's shoulder problem is not related to ALS, he relied on his own orthopedic expertise and concluded that the source of claimant's problems is mechanical. Claimant's medical expenses relating to his shoulder are part of his compensable injury.[3]

We also conclude that claimant has established an aggravation of that injury. Gallagher's chart notes from his closing examination in April, 1982, show that claimant had cramping, right shoulder pain but no muscle atrophy. His July, 1983, report notes that claimant has continued pain, cramping and freezing of the arm. The examination also revealed a loss of deltoid muscle. Tiley diagnosed muscle atrophy. Claimant has shown a worsening of his compensable condition since the last arrangement of compensation.

Reversed and remanded with instructions to accept the claim.

[3] Claimant also argues that a medical report generated over a month after hearing should be added to the record. The Board declined to remand for reconsideration of the report, and we deny claimant's motion to supplement the record. Claimant did not demonstrate that the report was not obtainable at the time of hearing. *See Compton v. Weyerhaeuser*, 301 Or 641, 724 P2d 814 (1986).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patricia M. Van Blokland, Claimant.

VAN BLOKLAND,
Petitioner,

v.

OREGON HEALTH SCIENCES UNIVERSITY et al,
Respondents.

(83-06632; CA A42003)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 20, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Karen M. Werner and Malagon & Moore, Eugene.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed and remanded with instructions to set aside denial of weight loss program payment and to reopen claim.

YOUNG, J.

Claimant seeks review of an order of the Workers' Compensation Board which affirmed the referee's award of an additional 35 percent unscheduled permanent partial disability of the low back, rejected claimant's contention that the claim had been prematurely closed and upheld SAIF's denial of payment for a weight loss program. On *de novo* review, we hold that the weight loss program is compensable and that the claim was prematurely closed.

Claimant is five feet six inches tall. Her weight has fluctuated from 234 pounds (in November 1981) to 300 pounds (in April 1983). She had compensable left knee surgeries in 1973, 1974, 1975 and 1976, which resulted in a total award of 25 percent permanent partial disability. In 1980, she re-injured the knee and was awarded an additional five percent permanent partial disability. Since at least October, 1980, after she re-injured her knee, claimant's doctors have advised her to lose weight. In January 1982, she developed low back pain due to altered body mechanics caused by her unstable knee. In April 1982, Dr. Eckhardt, her treating physician, performed a discectomy, and claimant was awarded 10 percent unscheduled permanent partial disability for the low back.

In the spring of 1983, claimant's weight increased to 300 pounds. She enrolled in a weight loss program and lost 12 pounds. In November 1983, Eckhardt rated claimant's left leg impairment as moderate and her back impairment as "mildly moderate." In December 1983, her back pain worsened and she was hospitalized. In March, 1984, Eckhardt noted that claimant's obesity "contributes significantly to * * * her overall back disability" and that a well supervised weight reducation program probably would be the most important treatment claimant could receive. On June 21, 1984, Dr. Achterman[1] asked SAIF to approve claimant's enrollment in the Risk Factor Obesity Program, because "for a patient of this type this is the only sort of program which will work."[2] SAIf offered to place claimant in Weight Watchers, and Achterman agreed. Claimant attended Weight Watchers for

eight weeks, lost 15 pounds and then stopped attending, because she was "no longer motivated" by the program.

In May 1985, Achterman and Dr. Misko both recommended the Risk Factor Obesity Program. Misko termed the program "essential" to claimant's recovery. In June, 1985, Orthopaedic Consultants examined claimant and concluded that she was medically stationary but that she should lose weight and that surgery was not indicated. On July 8, Misko repeated his request that SAIF enroll claimant in the Risk Factor Obesity Program.

In January, 1986, Misko reported that claimant was not medically stationary, because "I believe the Risk Factor Obesity Clinic is reasonable and necessary, and following her obtaining reasonable weight and if [she] still at that time

[1] Dr. Achterman became claimant's treating physician after Eckhardt retired.

[2] The Risk Factor Obesity Program is a highly structured and supervised weight loss program. The program accepts patients only on referral by a physician.

complains of back and leg pain that surgery would be indicated." Achterman wrote that claimant "is in definite need of treatment which can be offered through the Risk Factor Obesity Clinic."

> "It is my considered opinion that this patient is in definite need of treatment which can be offered through the Risk Factor Obesity Clinic. I do not feel that it is likely that this patient will benefit from a surgical exploration of her disc, until she has lost considerable weight. I would put the required weight loss in the range of 80-100 pounds.
>
> "Both Dr. Misko and I feel that in order to have any understanding as to the overall need for surgery in this patient, that the weight should be lost first. It may well be that with successful weight loss, that this patient would not be in need of the surgery which has been proposed."

The first issue is whether the weight loss recommended by the doctors is a compensable medical service under ORS 656.245(1), which provides, in part:

> "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."

SAIF argues that it is not liable for the weight loss program, because claimant's obesity is not a result of her injury. SAIF's contention that the "condition" in question is obesity is incorrect. The conditions intended to be ameliorated by the obesity program are claimant's compensable injuries. Although it is

true that the purpose of the Risk Factor Obesity Program is to help claimant lose weight, the program will also aid her in recovering from the compensable injuries and may avoid the need for surgery.

In *Williams v. Gates, McDonald and Company*, 300 Or 278, 709 P2d 712 (1985), the court held that, when two operations were required to treat a compensable injury, long-term, post-operative consequences of one of the operations were compensable, even though they resulted from an operation that the claimant *should* have had if she had never been injured. 300 Or at 281. The court focused on two factors: first, whether there was any indication that claimant *would* have had the operation that she should have had; and, second, whether both operations were required for total medical treatment.

Although *Williams* is not controlling in this case, it is instructive. There is no indication that claimant would have enrolled in the Risk Factor Obesity Program unless she had been injured, even though she was obese and her doctors had advised her to lose weight. Although Orthopaedic Consultants had declared her medically stationary, all the medical evidence indicates that she must lose considerable weight to recover. In other words, weight loss is required for total medical treatment.

Claimant is entitled to treatment for the disabling results of a compensable injury, even if pre-existing and continuing obesity contributes to the disability. *See Taylor v. SAIF*, 75 Or App 583, 586, 706 P2d 1023 (1985); *Hoffman v. Bumble Bee Foods, Inc.*, 15 Or App 253, 254, 515 P2d 406 (1973). The compensable injury need not be the sole cause or

the most significant cause of the need for treatment, but only a material contributing cause. *Jordan v. SAIF*, 86 Or App 29, ___ P2d ___ (1987); *see Lobato v. SAIF*, 75 Or App 488, 706 P2d 1025 (1985). The treatment must be reasonable and necessary. *Wait v. Montgomery Ward, Inc.*, 10 Or App 333, 335, 499 P2d 1340 (1972). We hold that claimant has shown by a preponderance of the evidence that the Risk Factor Obesity Program is a compensable medical treatment.

The next issue is whether the Board prematurely closed the claim. The evidence is persuasive that claimant's condition will improve if she loses significant amounts of

weight. The proposed weight loss treatment program is curative and not palliative. *See Schuening v. J. R. Simplot & Company*, 84 Or App 622, 735 P2d 1, *rev den* 303 Or 590 (1987). It will not be possible to determine the extent of the disability until she has had the treatment. The claim was prematurely closed.[3]

Reversed and remanded with instructions to set aside denial of the weight loss program payment and to reopen the claim.

[3] Because we conclude that the claim was prematurely closed, we need not reach claimant's alternative assignments of error.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis L. Priest, Claimant.

PRIEST,
Petitioner,

v.

SILCO CONSTRUCTION COMPANY et al,
Respondents.

(WCB 85-08762; CA A42733)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 2, 1987.

Thomas O. Carter, Portland, argued the cause and filed the brief for petitioner.

Allan M. Muir, Portland, argued the cause for respondents. With him on the brief were Dennis S. Reese and Schwabe, Williamson & Wyatt, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Reversed and remanded to referee for taking of additional evidence.

PER CURIAM

Claimant seeks review of a Workers' Compensation Board order that reversed the referee's order and reinstated

both the original determination order and the insurer's denial of responsibility for a proposed arthroscopy. We reverse and remand to the referee for the taking of additional evidence.

Claimant sustained a compensable right knee injury on March 20, 1985. He was awarded only time loss benefits by the determination order, and the claim was closed on July 3, 1985. On November 22, 1985, insurer denied responsibility for claimant's requested arthroscopic knee surgery. After a hearing, the referee found that the claim had been prematurely closed and reversed the denial of responsibility. The surgery was performed on July 16, 1986. The Board, without benefit of the surgeon's report, reversed the referee and reinstated both the determination order and insurer's denial of the arthroscopy. Under ORS 656.298(6), we "may remand the case to the referee for further evidence taking, correction or other necessary action,"[1] and we do so here so that the referee and the parties may have a full opportunity to develop the record in light of the post-hearing arthroscopy and the surgeon's report.[2]

Reversed and remanded to the referee for taking of additional evidence.

[1] ORS 656.298(6) was amended by Or Laws 1987, ch 884, § 12a, to delete, *inter alia*, the quoted language. The amendment will become effective January 1, 1988. Or Laws 1987, ch 884, § 63(1).

[2] We find the reasons to remand "compelling." *Brenner v. Industrial Indemnity Co.*, 30 Or App 69, 73, 566 P2d 530 (1977), because the post-surgical evidence concerns claimant's disability, was not available at the time of the hearing and involves a reasonable likelihood that the outcome of the case may be affected. *See Cain v. Woolley Enterprises*, 301 Or 650, 654, 724 P2d 819 (1986).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Eugene F. Clark, Claimant.

CLARK,
Petitioner,

v.

ERDMAN MEAT PACKING et al,
Respondents.

(WCB 84-06392; CA A39563)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1987.

Jim L. Scavera, Coos Bay, argued the cause and filed the brief for petitioner.

Lynne W. McNutt, Coos Bay, argued the cause for respondents Erdman Meat Packing and Fireman's Fund Insurance Company. With him on the brief was McNutt, McNutt & Thrush, Coos Bay.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondent North Pacific Insurance Company.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's opinion and order and denying benefits for claimant's back condition. The fundamental question is whether claimant's employment activities at Erdman Meat Packing Company was the major contributing cause of his back condition. We find that it was not and affirm.

Claimant sustained a nondisabling compensable lumbar strain while employed at Hatcher Construction Company in 1979. The injury produced sharp lower back pain approximately twice a month over a period of several years, but claimant never missed time from work due to the injury. Sometime in late 1981, claimant left Hatcher, and in January, 1982, he began work for Erdman. He occasionally performed heavy labor; however, he testified that his intermittent low back pain neither increased nor became more frequent as a result of the work. He once suffered a symptomatic episode off the job. He testified that he was driving to work when he experienced a sudden onset of severe low back pain that radiated down his right leg. That symptom was new. Despite that incident, he continued to work without any time loss. In May, 1982, he was laid off for reasons unrelated to the injury.

A subsequent myelogram revealed a large bulging defect in claimant's lumbar spine. His physician recommended surgery, and claimant filed an aggravation claim with Hatcher's insurer, SAIF. He did not file a claim with Erdman. SAIF denied the claim, based in part on medical reports by Drs. Brooks and Pasquesi. The physicians suggested that claimant's then existing condition was not likely to be the result of claimant's original lumbar sprain, and Brooks said that the disk herniation most likely occurred in 1983. Shortly before the hearing on that denial, claimant slipped and fell while hunting and sustained further injury to his back.[1]

Claimant's treating physician, Dr. Bert, testified by way of a deposition that claimant's employment at Erdman

independently contributed to the worsening of the disk condition. The referee affirmed SAIF's denial, reasoning that Hatcher could no longer be responsible for claimant's back condition under the last injurious exposure rule. *See Boise Cascade Corp. v. Starbuck*, 61 Or App 631, 659 P2d 424 (1983), *aff'd* 296 Or 238, 675 P2d 1044 (1984). That ruling was affirmed on judicial review. *Clark v. SAIF*, 74 Or App 365, 704 P2d 552 (1985).

[1] No evidence has been offered by either party as to the effect that this incident may have had on claimant's condition at the time when he filed his claim against Erdman.

Two days after the referee's order sustaining SAIF's denial, claimant filed the present claim, alleging that his employment duties there had contributed to his lower back condition. The claim was denied. The referee found that claimant's employment at Erdman independently contributed to his disability and that Fireman's Fund was the responsible insurer.

On appeal, the Board classified the claim as one for an "occupational disease" and ruled that claimant was required to demonstrate that working conditions at Erdman were the major contributing cause of his disk herniation. It concluded that the physician's reports failed to meet his burden of proving the required causal link between his occupational disease and the working conditions. The Board upheld the denial.

In *James v. SAIF*, 290 Or 343, 348, 624 P2d 565 (1981), the Supreme Court adopted our distinction between an injury and an occupational disease under the Workers' Compensation Law:

> "We have not had occasion to distinguish between 'injury' and 'disease.' The Court of Appeals did so in *O'Neal v. Sisters of Providence*, 22 Or App 9, 537 P2d 580 (1975), and approved the statement made in 1B Larson's Workmen's Compensation Law § 41.31: '"* * * What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can[not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden in onset. * * *" (Footnotes omitted.)' 22 Or App at 16."

Claimant's back condition developed over time and could not be viewed as wholly unexpected in view of his age, the heavy labor that he sometimes performed and his intermittent back

pain. Although Bert traces claimant's condition directly to his 1979 injury, both Brooks and Pasquesi conclude that it is unlikely that the disk herniation occurred then. Claimant has not pointed to any traumatic on-the-job occurrence which might have triggered the disk protrusion. We conclude that the Board's characterization of the claim as one for an occupational disease is correct.

A claimant must prove an occupational disease by a preponderance of the evidence. ORS 656.802(1)(a). The difficulty in this case is that both claimant's on-the-job and off-the-job activities may have contributed to his back condition. Claimant testified that he regularly participated in rigorous off-the-job activities, including horseback riding, wood cutting and hunting.

A claimant who suffers from a condition which is the result of both on-the-job and off-the-job causative agents must demonstrate that on-the-job factors were the major contributing cause of the condition. *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983); *Robinson v. SAIF*, 78 Or App 581, 717 P2d 1202 (1986). Each of the doctors offering opinions in this case concluded that claimant's working conditions contributed to his herniated disk, however, none of them commented specifically on the degree of their contribution. Brooks merely

indicated that it was possible that claimant's work activities caused his condition. Pasquesi stated that all of claimant's activities, both on and off the job, were probably factors in bringing about his disability. As already noted, Bert relates claimant's condition directly to his 1979 injury, but we find that theory implausible in view of the opinions offered by Brooks and Pasquesi.

On *de novo* review, we conclude that his condition is not compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carl A. Anfora, Claimant.

ANFORA,
Petitioner - Cross-Respondent,

v.

LIBERTY COMMUNICATIONS et al,
Respondents - Cross-Petitioners,

and

CABLE COMMUNICATIONS et al,
Respondents - Cross-Respondents.

(WCB 85-03807, 85-03808, 85-06955, 85-06956; CA A40575)

Judicial Review from Workers' Compensation Board.

On petitioner - cross-respondent's petition for attorney fees filed June 29, 1987; on respondents - cross-respondents' response to petition for attorney fees filed July 7, 1987. Former opinion filed June 17, 1987, 86 Or App 9, 737 P2d 977.

Roger Ousey and Bischoff & Strooband, P.C., Eugene, for petition.

Lydia E. Duncan and Kevin L. Mannix, P.C., Salem, for response.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Petition for attorney fees denied.

BUTTLER, P. J.

In this workers' compensation proceeding under ORS 656.307 to determine which of two employers is responsible for claimant's back condition, claimant petitioned and Liberty Communication cross-petitioned for judicial review of a Board decision holding that claimant had suffered an aggravation of a 1982 compensable injury sustained at Liberty. We reversed the Board and reinstated the referee's determination that claimant had suffered a new injury while working for Cable Communications (Cable). 86 Or App 9, 737 P2d 977 (1987). In his present petition, claimant asserts that, pursuant to ORS

656.382(2) and ORS 656.386(1), he is entitled to attorney fees payable by Cable, because he participated in the proceeding on review and succeeded in establishing here that he had suffered a new injury for which Cable is responsible.

Because Cable did not seek judicial review, this case does not fall within ORS 656.382(2),[1] which allows for attorney fees against an employer or insurer who initiates an appeal. *See Shoulders v. SAIF,* 300 Or 606, 609, 716 P2d 751 (1987).

Claimant is entitled to attorney fees under ORS 656.386(1)[2] if he finally prevailed on review "from an order or decision denying the claim for compensation." *Shoulders v. SAIF, supra,* 300 Or at 611. We have usually held that our review of a proceeding which decided only a question of responsibility is not review of "an order or decision denying the claim," because the claimant's right to compensation has not been affected. *Petshow v. Farm Bureau Ins. Co.,* 76 Or App

563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986). We have made exceptions and awarded fees under either ORS 656.382(2) or ORS 656.386(1), however, when, as a result of some technical challenge by the employer, a claimant has been required to appear and participate in order to avoid a loss of compensation. *See Stovall v. Sally Salmon Seafood,* 84 Or App 612, 615, 735 P2d 18, *rev allowed* 304 Or 240 (1987); *Nat. Farm Ins. v. Scofield,* 56 Or App 130, 641 P2d 1131 (1982); *Hanna v. McGrew Bros. Sawmill,* 44 Or App 189, 605 P2d 724, *mod* 45 Or App 757, 609 P2d 422 (1980). This is not such a case.

Although claimant may have initiated review in order to secure an extended period during which he would have aggravation rights and, in fact, succeeded in that objective, at no time was his right to compensation on the present claim at risk. We conclude, for that reason, that ORS 656.382(2) does not entitle him to attorney fees for prevailing against Cable on review.

Petition for attorney fees denied.

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[1] ORS 656.382(2) provides:

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

[2] ORS 656.386(1) provides, in part:

"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 THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Earl H. Norby, Claimant.

NORBY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-06365; CA A36929)

On remand from the Oregon Supreme Court, *Norby v. SAIF,* 303 Or 536, 738 P2d 974 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand June 30, 1987.

David C. Force, Eugene, for petitioner.

Darrell E. Bewley, Assistant Attorney General, Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem, for respondents.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

This case is on remand from the Supreme Court for a determination of claimant's disability resulting from a compensable back injury. The question raised by claimant on our initial review was whether the Board had properly considered the fact that he had already received a 10 percent award for an earlier back injury in determining that he had been adequately compensated for disability related to his back and was not entitled to an additional award of permanent partial disability after the most recent injury. We held that it had. 82 Or App 157, 160, 728 P2d 55 (1986). The Supreme Court correctly understood our opinion as having dealt with that legal question only, not as having reevaluated the extent of claimant's disability. 303 Or 536, 738 P2d 974 (1987).

On remand, we review the question of extent of disability *de novo.* We have considered the medical evidence and conclude that claimant is not entitled to an additional award for permanent partial disability. Dr. Carlstrom, claimant's chiropractor, believed that the entire disability resulting from the successive back injuries that he has suffered is mild to moderate. Drs. Degge and Fry conclude that the back condition with respect to the most recent injury has resolved and that he suffers no permanent disability. Fry, an orthopedist, notes that claimant's height makes him susceptible to back pain and, for that reason, recommends that he change to a less strenuous employment. Degge, an orthopedic surgeon,

believes that the fact that claimant has an extra lumbar vertebra makes him susceptible to back strain; he also recommends a job change. Neither Fry nor Degge believes that the most recent injury resulted in permanent disability. We conclude that the most persuasive medical evidence shows that claimant is not entitled to an additional award of permanent partial disability.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Martin Greenslitt, Claimant.

GREENSLITT,
Petitioner,

v.

CITY OF LAKE OSWEGO et al,
Respondents.

(WCB No. 82-00591; CA A41824)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 1, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

The issue in this case is whether an employer or claimant who is dissatisfied with a referee's attorney fees award must take the dispute to the Workers' Compensation Board or to Circuit Court. Claimant successfully resisted employer's denial of the compensability of his occupational disease claim before a referee, and on employer's appeal the Board affirmed on compensability. However, it reduced the referee's attorney fees award, and claimant seeks review of that portion of its order. We hold that the Board was the proper forum for the attorney fees dispute under the facts of this case and, therefore, affirm.

In *SAIF v. Anlauf*, 52 Or App 115, 627 P2d 1269

(1981), we held that ORS 656.386(1)[1] and ORS 656.388(2),[2] which provide for circuit court review of attorney fees awards under certain circumstances, are not the exclusive method of obtaining review of a referee's attorney fees award but, rather, are an alternative to the normal Board review. In *Farmers Ins. Group v. SAIF,* 301 Or 612, 619, 724 P2d 799 (1986), the Supreme Court stated, in *dictum,* that "any disagreement regarding the amount of attorney fees awarded by a referee is not subject to the ordinary board review procedures of ORS 656.295, but is to be resolved [by the circuit court] under the unique provisions of ORS 656.388(2)." Because the Supreme

Court's statement is *dictum,* it does not, as claimant seems to assume, directly overrule our holding in *Anlauf.* However, it, a subsequent amendment to that statute and the need to consider another statute which we did not mention in *Anlauf* do justify another examination of the subject. That reexamination leads us to modify our previous holding.

We begin with the original purposes of ORS 656.386(1) and ORS 656.388(2). The legislature adopted earlier versions of them, before the creation of the present workers' compensation system in 1965. At the time, all covered employers had to insure with the State Industrial Accident Commission (SIAC). SIAC conducted hearings and issued final orders awarding or denying compensation. A claimant could appeal from a SIAC award to the circuit court; the employer was neither an interested party nor a participant in the proceedings before SIAC or in court. *See former* ORS 656.272 to ORS 656.290 (*repealed or amended by* Or Laws 1965, ch 285, § 95). Thus, only SIAC and the claimant or the claimant's attorney were interested in the amount of the attorney fees.

Before 1951, SIAC was only authorized to allow a fee to be paid from a claimant's compensation award. ORS 656.388(1) (formerly ORS 656.590(1)) is the current version of that statute; intervening amendments have not made any relevant changes. An attorney who was dissatisfied with the award could seek immediate circuit court review of the award without having to appeal the entire case. *Former* ORS

[1] 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. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be set as provided for in ORS 656.388 (2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

An occupational disease is effectively treated as an injury under the Workers' Compensation Act. ORS 656.804.

[2] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

656.590(2) (now ORS 656.388(2)). In 1951, the legislature required SIAC to pay attorney fees in addition to, rather than out of, compensation when a claimant successfully appealed SIAC's rejection of a claim. Or Laws 1951, ch 330, § 2 (codified as ORS 656.588; now ORS 656.386).[3] A 1957 amendment,

Oregon Laws 1957, ch 558, § 1,[4] also required SIAC-paid fees in cases where the claimant prevailed on appeal to the Commission from a hearings officer and provided that disputes over the amount of the fees would go to circuit court under the same procedures as if the fees came from the compensation award.

In short, circuit court review of fee disputes began as a streamlined method of bringing the issue to the court which had appellate jurisdiction over SIAC orders in cases where the merits were no longer contested. Because SIAC both adjudicated claims and administered the fund from which they were paid, it had an apparent conflict in deciding attorney fees questions. The procedure was designed to overcome that conflict. When the legislature abolished SIAC in 1965 and created the Workers' Compensation Board as a purely adjudicative body, it retained the previous rights to attorney fees and the previous procedure for resolving disputes concerning them, simply giving formal recognition to the role of the hearings officer (presently known as the referee). Or Laws 1965, ch 285, §§ 42a, 42b (*amending* ORS 656.588 and ORS 656.590 (now ORS 656.386 and ORS 656.388)). Neither then nor since has the legislature explicitly provided for an *employer* to seek review of a fee award. Much of the statutory language, read literally, makes sense only in the context of the pre-1965 compensation system. The statutes can, however, be read in a fashion which is compatible with the present system.

Before making that reading, we note an additional relevant provision which neither party mentions. The 1965 legislature was concerned that, under the new system, an insurer might have an incentive to fight claims from one level to another, hoping that the claimant would eventually give up.

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[3] Or Laws 1951, ch 330, § 2, provides:

"In all cases involving accidental injuries occurring on or after July 1, 1951, where an injured workman prevails in an appeal to the circuit court from a commission order rejecting his original claim for compensation, the commission shall allow a reasonable attorney fee to the claimant's attorney, which said attorney fee shall be paid from the Industrial Accident Fund as an administrative expense. In all other cases attorney fees shall continue to be paid from the claimant's award of compensation."

[4] Or Laws 1957, ch 558, § 1, amended *former* ORS 656.588(1) (now ORS 656.386(1)) to provide:

"In all cases involving accidental injuries occurring on or after July 1, 1957, where a claimant prevails in an appeal to the circuit court from a commission order rejecting his original claim for compensation, the court shall allow a reasonable attorney's fee to the claimant's attorney. In such rejected cases where the claimant prevails in his appeal before the commission itself, then the commission shall allow a reasonable attorney's fee; however, in the event a dispute arises as to the amount allowed by the commission, that amount may be settled as provided for in subsection (2) of ORS 656.590 [now ORS 656.388(2)]. Attorney fees provided for in this section shall be paid from the Industrial Accident Fund as an administrative expense."

It therefore adopted ORS 656.382(2),[5] requiring an employer or insurer to pay the claimant's attorney fee in all cases if it initiated the review and lost on the merits. *See Bracke v. Baza'r*, 294 Or 483, 487-488, 658 P2d 1158 (1983). That statute is the *sole* basis for an award of attorney fees when an *employer* initiates the review. *Shoulders v. SAIF*, 300 Or 606, 716 P2d 751 (1986). It does not provide for disputes to be resolved in the circuit court by the procedure established in ORS 656.388(2), which can apply *only* when the claimant has initiated the most recent level of review.

ORS 656.386(1) allows a referee to award attorney fees in denied cases "where the claimant *prevails finally* in a hearing before the referee * * *." (Emphasis supplied.) If the claimant "prevails finally" before the Board, then it sets the fee. If the referee rules in favor of a claimant and the employer seeks Board review of compensability, the claimant has not prevailed finally before the referee; that does not occur until the review process is completed favorably to the claimant. Thus the referee's fee award is only tentative; like the rest of the referee's order, the Board may "affirm, reverse, modify or supplement" it. ORS 656.295(6). When the employer seeks review of compensability, the attorney fees provisions of ORS 656.386(1) no longer apply and neither do the provisions of ORS 656.388(2). The Board has the sole authority to set the attorney fees in that circumstance, subject to appellate review.[6]

If, however, the employer accepts the referee's compensability decision and contests only the fees award, the situation is different. ORS 656.386(1) presently provides, in

part, "[i]n the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount *shall* be set as provided for in ORS 656.388(2)." (Emphasis supplied.) At the time of our decision in *SAIF v. Anlauf, supra*, the statute read "that amount *may* be settled as provided for in subsection (2) of ORS 656.388." (Emphasis supplied.) We relied on the word "may" in holding that the procedure was not exclusive. 52 Or App at 119. The 1983 legislature changed "may" to "shall." Or Laws 1983, ch 568, § 2. The only apparent reason for the amendment was to make the procedure a requirement instead of an alternative. Thus, when a referee's decision is the final determination of the compensability of a denied claim, the *only* way to obtain review of the attorney fees award is through the circuit court procedure under ORS

[5] ORS 656.382(2) presently provides:

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

[6] When the Board affirms a finding of compensability, the award for services at the hearing before the referee is no longer the referee's award under ORS 656.386(1). The Board's adoption or modification of it makes it an award *by the Board* under ORS 656.382(2) for "legal representation by an attorney for the claimant at *and prior to*" the Board's review. (Emphasis supplied.)

656.388(2).[7] We overrule *SAIF v. Anlauf, supra*, to the extent that it is inconsistent with these conclusions.

ORS 656.388(2) provides that, if an attorney and the referee or Board cannot agree on the amount of the fees, each shall submit "a written statement of the services rendered" to the circuit court. That language assumes that the attorney involved is the claimant's attorney; in the pre-1965 context that was an appropriate assumption. However, it does not foreclose an employer's attorney from initiating the process; the claimant would then be entitled to participate in it. We held in *SAIF v. Huggins*, 52 Or App 121, 627 P2d 1272 (1981), that the procedure is available to either party, and we adhere to that holding. The legislature simply neglected to modify language which became outdated with the change in the system in 1965.

Because in this case employer sought Board review of the referee's compensability determination, the Board had jurisdiction to review the attorney fee award. Claimant does not attack the Board's action on the merits. We therefore affirm the Board.

Affirmed.

[7] Similarly, if the claimant is dissatisfied with the referee's fee award and the employer seeks Board review of compensability, the claimant may then obtain Board review of the fees award. *See* ORS 656.289(3). If the employer does not seek Board review of compensability, the claimant has prevailed finally before the referee and must take the dispute to circuit court.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marvin L. Noffsinger, Claimant.

NOFFSINGER,
Petitioner,

v.

YONCALLA TIMBER PRODUCTS et al,
Respondents.

(WCB 84-12362; CA A38416)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Darrell E. Bewley, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's denial of temporary disability benefits. We affirm.

Claimant was employed as a millworker at Yoncalla Timber. He testified that for a period of approximately two years he had been experiencing "mental stress" due to pressure and harassment at work. On April 11, 1984, he was fired. The following day he saw Dr. Wiltse for symptoms related to stress. On April 24, Wiltse filled out a form releasing claimant for "regular work" but indicating that he was not medically stationary. Wiltse explained in a letter that he was in favor of claimant's working, but not at Yoncalla. Within two weeks of claimant's discharge, he applied for unemployment benefits, which he began receiving.[1]

On May 14, 1984, claimant filed a claim for occupational stress, which we upheld on review. *SAIF v. Noffsinger*, 80 Or App 640, 723 P2d 358, *rev den* 302 Or 342 (1986). SAIF accepted the claim as nondisabling in March, 1985, and has refused to pay any temporary disability compensation. Claimant contends that he is entitled to temporary disability benefits, because he was not medically stationary and because Wiltse's release did not constitute a release to return to "regular work." SAIF argues that claimant is not entitled to temporary disability because he was released for "regular work."

Both parties focus on the provisions of ORS 656.268, which govern the termination of temporary disability compensation. That statute provides that "[c]laims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary * * *." ORS 656.268(1). Subsection (2) states:

> "When the injured worker's condition resulting from a *disabling injury* has become medically stationary, unless the injured worker is enrolled and actively engaged in training, the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if

> any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the Evaluation Division and to the worker and to the employer, if requested by the worker or employer. If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section. If the attending physician has approved the worker's return to the worker's regular employment and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of any vocational assistance provided by this chapter." (Emphasis supplied.)

ORS 656.268 deals with the termination of benefits

[1] Claimant's request for temporary total disability is inconsistent with his claim for unemployment benefits. *See Wells v. Pete Walker's Auto Body*, 86 Or App 739, 740 P2d 245 (1987).

for, or the closure of, a claim which has previously been accepted as disabling. Here, SAIF has never paid temporary total disability benefits and has never acknowledged that the claim is disabling. Even so, SAIF relies on the language of ORS 656.286(2) for its statement that temporary total disability benefits may be terminated when a claimant has been released for regular employment. Although that factor may be relevant to a determination of whether a claimant is disabled, the statute itself does not resolve the present problem.

The direct question presented is whether claimant is or has ever been disabled from work as a result of his compensable stress claim. As recognized by the Supreme Court in *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985), the entire scheme of the Workers' Compensation Law is to compensate workers "for wages lost because of inability (or reduced capacity) to work as a result of a compensable injury." Claimant's doctor released him for "regular work," including the millwork that he had done before, but recommended that he not return to Yoncalla because of his reaction to stress peculiar to that work place. The evidence establishes that claimant left work at Yoncalla because he was fired, not because he was disabled. He is not precluded from working for any other employer. We conclude that he has not lost wages because of an inability to work as a result of his compensable condition and that, therefore, he is not entitled to temporary disability benefits.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Margie M. Guill, Claimant.

GUILL,
Petitioner,

v.

PENDLETON WOOLEN MILLS,
Respondent.

(WCB No. 85-09065; CA A42368)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 6, 1987.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Mildred J. Carmack, Portland, argued the cause for respondent. With her on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant prevailed before the referee in establishing the compensability of her injury claim. Employer appealed to the Workers' Compensation Board, which affirmed the referee on compensability but reduced the fee which the referee had awarded claimant's attorney. Claimant seeks judicial review of that action. She argues, first, that jurisdiction to modify a referee's attorney fees award is solely in the circuit court under ORS 656.386(1) and ORS 656.388(2). Because employer sought Board review of compensability, claimant is wrong. *Greenslitt v. City of Lake Oswego*, 88 Or App 94, ___ P2d ___ (1987). On *de novo* review, we find no reason to disturb the Board's decision.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Carolyn K. Barr, Claimant.

BARR,
Petitioner - Cross-Respondent,
v.
EBI COMPANIES et al,
Respondents - Cross-Petitioners,
and
SAIF CORPORATION et al,
Respondents.

(WCB 84-04731, WCB 85-05501; CA A40548)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 10, 1987.

Lawrence B. Rew, Pendleton, argued the cause for petitioner - cross-respondent. With him on the brief was Corey, Byler, Rew, Lorenzen & Hojem, Pendleton.

Jerald P. Keene, Portland, argued the cause for respondents - cross-petitioners EBI Companies and Villa Royal Health Care. With him on the brief was Roberts, Reinisch & Klor, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Amber Valley Care Center. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Affirmed.

WARDEN, P. J.

Claimant petitions for review of a Workers' Compensation Board order that affirmed the referee's order denying benefits. The Board agreed with the referee that claimant's initial hearing request on EBI's denial was premature and that she had failed to establish good cause for her untimely second hearing request. We affirm.[1]

Claimant sustained a compensable injury while working for Villa Royal Health Care, EBI's insured, in March, 1979. In January, 1984, claimant became disabled while working for SAIF's insured. She filed a claim for occupational disease, which SAIF denied.

On February 24, 1984, claimant mailed EBI notice of a claim for aggravation of her 1979 injury. EBI received it on February 27. Claimant filed a request for hearing on April 26, 59 days after EBI had received the claim and 62 days after claimant had mailed the notice of claim. EBI denied the claim on May 7. Claimant filed another request for hearing on July 12, more than 60, but fewer than 180, days after EBI's denial.

On review, claimant contends that the Board erred in dismissing her claim, arguing that her first hearing request was not premature and that she had shown good cause for the untimely filing of her second hearing request. We first address the issue of the prematurity of the April hearing request.

In order to obtain medical services or disability compensation on an aggravation claim, a claimant must "file" the claim with the insurer or self-insured employer, ORS 656.273(2), which must accept or deny it within 60 days after "notice or knowledge of the claim," ORS 656.262(6), or risk imposition of penalties and the assessment of attorney fees. ORS 656.262(10); ORS 656.382. A claim is deemed denied *de facto* after expiration of the 60-day period, if the insurer or self-insured employer has not accepted or denied it. *Syphers v. K-W Logging, Inc.*, 51 Or App 769, 771, 627 P2d 24, *rev den* 291 Or 151 (1981). A claimant may request a hearing on a denial within 60 days after either "the mailing of the notice of denial," ORS 656.262(8), or the *de facto* denial. *Syphers v.*

K-W Logging, Inc., supra. A premature request for a hearing on the issue of whether a claim should be accepted is ineffective and void. *Syphers v. K-W Logging, Inc., supra.*

Claimant equates EBI's "notice or knowledge" of her aggravation claim with her mailing of the notice of that claim and would compute the 60-day period during which EBI had to accept or deny it as beginning on the date of that mailing. By that computation, her April 26, 1984, request for hearing would not be premature. She relies on *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), and *Madewell v. Salvation Army*, 49 Or App 713, 620 P2d 953 (1980). Those cases, however, are not helpful to her, and she overlooks *Bergeron v. Ontario Rendering Co.*, 34 Or App 1025, 580 P2d 216, *rev den* 284 Or 80 (1978), in concluding that they are helpful.

[1] At oral argument claimant abandoned her petition as to SAIF and Amber Valley Care Center, its insured, and we therefore affirm as to those respondents also. Because we affirm on the petition, we need not address EBI's cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dena M. Smith, Claimant.

SMITH,
Petitioner,

v.

RIDGEPINE, INC. et al,
Respondents.

(WCB 85-05567; CA A41505)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 11, 1987.

J. Michael Casey, Portland, argued the cause for petitioner. With him on the brief was Doblie & Associates, Portland.

Patric J. Doherty, Portland, argued the cause for respondents. With him on the brief were Ronald W. Atwood and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Affirmed.

WARDEN, P. J.

In this workers' compensation case, claimant seeks review of a Board order which affirmed the referee's holding that claimant is not entitled to temporary total disability (TTD) benefits. We affirm.

Claimant sustained a low back injury on February 8, 1980. She saw Dr. Fredstrom that day and again 10 days later, when he found her to be asymptomatic except for pain that she claimed to experience when doing heavy lifting. United Pacific Insurance accepted her claim as nondisabling, and she did not contest that. ORS 656.262(6). She received further treatment for her low back injury in 1983, and then that treatment was apparently billed to and paid by United.

A letter from Dr. Kovachevich, dated February 11, 1985, was claimant's first claim for TTD benefits. The referee determined that the claim was barred under *former* ORS 656.262(10) (*now* ORS 656.262(12)) and ORS 656.273(4)(b), because it was filed more than five years after the 1980 nondisabling injury. The Board affirmed on the ground that claimant had removed herself from the workforce in 1983. We affirm on the ground stated by the referee.

At the time of claimant's initial injury in 1980, ORS 656.262(10) provided, in pertinent part:

"A claim that a nondisabling injury has become disabling,

if made more than one year after the date of injury, *shall be made pursuant to ORS 656.273 as a claim for aggravation.*" (Emphasis supplied.)

At the same time, ORS 656.273(4) provided, in pertinent part:

"(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under [ORS 656.268(3)].

"(b) If the injury was nondisabling and no determination was made, the claim for aggravation *must be filed within five years after the date of injury.*" (Emphasis supplied.)

Claimant's claim must be treated as an aggravation claim under ORS 656.273, because it was made on the basis that her previously nondisabling injury had become disabling more than one year after the date of injury. The insurer first

received notice of the claim on February 19, 1985, by Kovachevich's letter of February 11, 1985. It follows that the claim is barred, because claimant did not file it within five years of her injury.

Affirmed.[1]

[1] The Board affirmed the referee's awards to claimant for medical services and attorney fees, and those awards are not challenged by either employer or insurer.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

McGAUGHEY et al,
Appellants,
v.
ST. PAUL FIRE AND MARINE INSURANCE COMPANY,
Respondent.

(85-C-614752; CA A42702)

Appeal from District Court, Multnomah County.

Robert L. Kirkman, Judge.

Argued and submitted September 11, 1987.

Richard S. Yugler, Portland, argued the cause and filed the brief for appellants.

Paul Silver, Portland, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

This is an action for breach of a comprehensive general liability insurance contract issued by defendant to plain-

tiffs, who seek to recover the cost of defending a workers' compensation claim. The claim was filed by plaintiffs' former employe. Plaintiffs tendered defense of the claim, and defendant refused the tender. The trial court held that, under the terms of the insurance contract, defendant had no duty to defend. Plaintiffs appeal, and we affirm.

Plaintiffs own and operate a trailer park. They hired Mrs. Sauer to manage the park, and she lived in a house located there. On April 16, 1985, she was fired as manager, but she was allowed to remain in the house until May 1. On April 22, she broke her leg at the park. She filed a workers' compensation claim, which was denied. She requested a hearing. Plaintiffs tendered the defense of the claim to defendant, which rejected it on the ground that the insurance contract excludes coverage of workers' compensation claims. The hearings referee ruled that Sauer's claim was not compensable under the workers' compensation law, because she was not a covered worker.

The procedural posture of this case is murky and requires explanation. Defendant filed an amended answer admitting the material factual allegations of the complaint, and denying, *inter alia*, that it breached the insurance contract when it rejected the tender. At trial, plaintiffs argued that the trial court should first decide whether the contract, which was attached to the complaint, was ambiguous. If it was, a jury would have to decide the factual issue. If the contract was not ambiguous, then there were only legal issues, which the court would decide. The trial court agreed and decided that the contract is not ambiguous and that defendant did not breach it "by refusing to provide a defense to the Workers' Compensation claim" and entered judgment for defendant.

Plaintiffs contend that the exclusionary clause in the contract is ambiguous. Whether the clause is ambiguous is a question of law. *Adams v. Northwest Farm Bureau Ins.*, 40 Or App 159, 164, 594 P2d 1256, *rev den* 287 Or 123 (1979). Words or terms in an insurance contract are ambiguous when "they could reasonably be given a broader or a narrower meaning, depending upon the intention of the parties in the context in

which such words are used by them." *Shadbolt v. Farmers Insur. Exch.*, 275 Or 407, 551 P2d 478 (1976). The allegedly ambiguous language must be reasonably susceptible of more than one meaning. *Western Fire Insurance Co. v. Wallis*, 289 Or 303, 308, 613 P2d 36 (1980). Language not reasonably susceptible of more than one meaning should not be rendered ambiguous "by attributing possible but unlikely meanings to the terms employed without some basis in the policy for doing so." 289 Or at 308. If an insurance contract is ambiguous, the meaning of the ambiguous term is a question of fact. *A-1 Sandblasting v. Baiden*, 53 Or App 890, 893, 632 P2d 1377 (1981), *aff'd* 293 Or 17 (1982).

The relevant clauses of the insurance contract provide:

"WHAT THIS AGREEMENT COVERS

"* * * * *

"**Defending lawsuits.** We'll defend any suit brought against you or any other protected person for covered claims, even if the suit is groundless or fraudulent. * * *

"EXCLUSIONS - CLAIMS WE WON'T COVER

"**Workers Compensation.** We won't cover obligations that protected persons or their insurance companies have under workers compensation, unemployment compensation, disability benefits or similar laws." (Emphasis in original.)

The contract is not ambiguous. Defendants had a duty to defend *any covered claim,* even if groundless. By the clear terms of the contract, workers' compensation claims are "claims we won't cover." Defendant had no duty to defend, because the claim filed by Sauer with the Workers' Compensation Department was not a covered claim as defined by the contract. A reasonably intelligent and careful person in the position of plaintiffs could not have understood the contract to mean anything else. *State Farm Mutual Auto. Ins. Co. v. White,* 60 Or App 666, 672, 655 P2d 599, *rev den* 294 Or 569 (1983).

Affirmed.[1]

[1] In view of this disposition, we need not consider plaintiffs' other assignments of error.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth Dalgliesh, Claimant.

DALGLIESH,
Petitioner,

v.

SCOTT et al,
Respondents.

(WCB 84-08363; CA A40624)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs March 25, 1987.

Charles Robinowitz, Portland, filed the briefs for petitioner.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and John A. Reuling, Jr., Assistant Attorney General, Salem, filed the brief for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed as modified.

PER CURIAM

Claimant challenges an award of permanent partial disability. On *de novo* review, we affirm the Board's award as to claimant's left leg and right shoulder and modify the order to award claimant permanent partial disability to the extent of 75 percent for his right arm.

Affirmed as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lee E. Short, Claimant.

SHORT,
Respondent,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Appellants.

(A8606-03219; CA A41221)

Appeal from Circuit Court, Multnomah County.

Charles S. Crookham, Judge.

Argued and submitted May 8, 1987.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for Appellants. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Richard A. Sly, Portland, argued the cause for respondent. With him on the brief was Bloom, Marandas & Sly, Portland.

Before Buttler, Presiding Judge, and Rossman and Deits, Judges.

BUTTLER, P. J.

Reversed.

BUTTLER, P. J.

SAIF appeals from a judgment of the circuit court entered pursuant to ORS 656.388(2) requiring it to pay attorney fees in addition to the amount previously ordered by the Workers' Compensation Board and approved by this court on review. The question is whether the circuit court had the authority to revise the amount of fees ordered by the Board when the insurer initiated Board review. We hold that it did not and, therefore, reverse.

Claimant suffered a compensable injury on February 1, 1977, when she fell down a flight of stairs and struck her head. Her claim was closed in July, 1979, and she was awarded 35 percent unscheduled disability for her neck and "mild psychological conditions." In September, 1982, she requested a reopening of her claim on the basis of a newly diagnosed organic brain injury. SAIF denied the request, and a hearing was held on January 5, 1984; the referee ordered that the claim be reopened as of September 29, 1982, imposed a penalty on SAIF for unreasonable delay in denying the claim and in paying interim compensation and awarded attorney fees of $500 in connection with the penalty issues and $2,000 on reversal of the denial.

SAIF appealed to the Board, arguing that claimant's newly diagnosed condition was not compensable and, in the

alternative, that a later reopening date was appropriate. Claimant filed a cross-appeal, contending that the reopening date should be earlier than that ordered by the referee. On February 13, 1985, the Board modified the referee's order, delaying the reopening date to March 30, 1983. The penalty and associated attorney fees were reduced. The attorney fee for prevailing on the denied claim was increased to $3,750 and an additional fee of $750 was awarded on the Board review.

Claimant petitioned this court for review and assigned error to, among other things, the amount of attorney fees awarded by the Board. We modified the Board's order as to the date of reopening, holding that September 1, 1982, was the proper date. We reinstated the referee's order regarding the penalty issue and affirmed the Board's award of attorney fees:

"Finally, we affirm the Board's award of attorney fees for

prevailing on SAIF's denial. The Board considered all of the evidence submitted by claimant's attorney and increased the fee awarded by the referee to $3,750, finding that an extraordinary fee was warranted. The Board also awarded $750 for services on Board review. On claimant's motion for reconsideration, the Board declined to increase the attorney fees award. The award does not appear to be unreasonable, and we defer to the Board in the light of its frequent determinations in this area; it may be expected to make consistent and knowledgeable assessments of the attorney effort involved." *Short v. SAIF*, 79 Or App 423, 429, 719 P2d 894 (1986).

Shortly after that decision, claimant petitioned the circuit court for an increase in the fees award, pursuant to ORS 656.388(2), which then provided:

"If an attorney and the referee or board or appellate court cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge of the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

The circuit court raised the fees award to $12,000 and ordered SAIF to pay that amount, less $4,750 that it had already paid. SAIF appeals, arguing that the court lacked jurisdiction to adjust the award and, in the alternative, that the fees that it awarded were excessive.

Claimant argues that her right to recover attorney fees stems from ORS 656.386(1),[1] which allows either party to contest fees in circuit court by the procedure provided in ORS 656.388(2). ORS 656.386(1) provides for insurer-paid attorney fees when the claimant has prevailed finally on an appeal from

[1] At the relevant time, ORS 656.386(1) provided:

"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. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

an order or decision denying the claim. In this case, the referee had determined that the claim should be reopened; he did not deny the claim. Employer sought Board review, and claimant prevailed *finally* on compensability before the Board. Because claimant did not prevail finally before the referee, her attorney fees could not be awarded pursuant to ORS 656.386(1). SAIF sought Board review of the referee's order, and attorney fees were awarded pursuant to ORS 656.382(2),[2] which is the sole basis for an award of employer paid fees when an employer initiates the final review process. *Shoulders v. SAIF*, 300 Or 606, 615, 716 P2d 651 (1986); *Greenslitt v. City of Lake Oswego*, 88 Or App 94, ___ P2d ___ (1987). That statute does not provide for circuit court review of attorney fees. Accordingly, there was no statutory basis for the circuit court to review the fees awarded by the Board in this case.

Reversed.

[2] At the relevant time, ORS 656.382(2) provided:

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

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wesley E. Crooke, Claimant.

CROOKE,
Petitioner - Cross-Respondent,
v.
GRESHAM TRANSFER et al,
Respondents - Cross-Petitioners.

(WCB 83-11486; CA A40340)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 3, 1987.

Linda C. Love, Portland, argued the cause for petitioner - cross-respondent. On the brief were James L. Francesconi and Francesconi & Cash, P.C., Portland.

Bruce L. Byerly, Portland, argued the cause for respondents - cross-petitioners. With him on the brief was Moscato & Byerly, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

On petition, referee's order reinstated; affirmed on cross-petition.

WARREN, J.

In this workers' compensation case, claimant seeks review of the Board's decision reversing the referee in part and holding that his psychologist could not provide medical verification of inability to work. Employer cross-petitions, seeking a determination that claimant's aggravation claim for a psychological condition and globus syndrome (a choked up feeling in the throat) is not compensable. We affirm on the cross-petition and write only to address the issue raised by claimant.

Claimant worked for employer as a truck driver until 1980, when he injured his arm on the job. Through vocational rehabilitation he obtained employment as a painter in July 1983 but was laid off in December 1983 due to a lack of work. He has not been able to find work since that time.

He was referred by his attorney to Drs. Colistro and Bowes in December 1983 for evaluation of globus syndrome and depression. At the time, Colistro was a psychologist licensed by the State Board of Psychologist Examiners. ORS 675.030. Bowes was a resident psychologist entitled to work under the supervision of a licensed practitioner. On April 26, 1984, Colistro and Bowes wrote a letter to claimant's attorney, stating that claimant would not be "ready to assume the demands of a new job" until he had undergone psychological counseling. The Board ultimately determined that claimant's globus and psychological conditions, claims for which had been denied by employer, were compensable but reversed the referee in part holding that claimant was not entitled to temporary disability because there had been no medical verification by one authorized to give it that claimant was unable to work.

ORS 656.273(6) provides, in part:

> "[T]he first installment of compensation due under ORS 656.262(4) shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition."

The statutes do not discuss who is authorized to provide medical verification so as to trigger an employer's obligation to begin paying interim compensation on an aggravation claim.

We conclude, however, that the answer can be ascertained from the legislative history.

Until 1975, ORS 656.273(4) required that a claim for aggravation "be supported by a written opinion of a physician that there are reasonable grounds for the claim." The legislature deleted that subsection and added present subsection (3), which states that "[a] physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." Or Laws 1975, ch 497, § 1. Thus, the section no longer precludes the making of an aggravation claim without a supporting medical opinion. At the same time, the legislature added subsection (6), which establishes the requirement for medical verification of time loss. Thus, the

legislature altered the substantive prerequisites for an aggravation claim, deleting the *requirement* of a physician's report; however, it retained the element of medical documentation with respect to time loss. There is no reason to doubt that the legislature intended that that documentation come from a "physician," as required under the pre-1975 version of ORS 656.273(4) and as is presently permitted by ORS 656.273(3), and we conclude that it must.

ORS 656.005(13) defines "physician," for purposes of workers' compensation, as "a person duly licensed to practice one or more of the healing arts." This case turns, therefore, on whether the practice of psychology is a healing art. Psychologists must be licensed to practice and are subject to regulation and discipline by the State Board of Psychologist Examiners. ORS 675.100. The "practice of psychology" is defined, in part, as

> "the diagnosis, prevention, treatment and amelioration of psychological problems and emotions and mental disorders of individuals and groups." ORS 675.010(4).

The scope of the practice of psychology certainly encompasses elements which are considered to be "healing." Although it has nowhere directly described psychology as a healing art, the legislature has impliedly viewed it as one in ORS 675.090(4), which defines those who are not subject to the regulation of the State Board of Psychologist Examiners to include "[a]ny person licensed to practice one or more of *the other healing arts* in the state of Oregon so long as the person does not apply

either of the specific terms of 'psychologist' or 'psychometrist' to that person's practice." (Emphasis supplied.)

We conclude that psychologists practice one of the healing arts as the term is used in ORS 656.005(13) and that they are therefore capable of providing medical verification of an inability to work as required by ORS 656.273. We held, on *de novo* review, that Colistro's report of April 26, 1984, stating that claimant "would not be ready to assume the demands of a new job" until he had undergone psychological counseling, was medical verification of an inability to work as of that date.

On petition, referee's order reinstated; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Terry L. Hunter, Claimant.

HUNTER,
Petitioner,

v.

TELEDYNE WAH CHANG et al,
Respondents.

(WCB No. 84-13275; CA A39205)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Bradley R. Scheminske, Portland, argued the cause for respondents. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed; referee's order reinstated.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee's order requiring insurer to pay "interim compensation" pending Board review of an earlier referee's decision awarding interim compensation. ORS 656.313.[1] We reverse.

Claimant requested a hearing on employer's denial of his occupational disease claim. The referee upheld the denial but awarded interim compensation, relying on our decision in *Bono v. SAIF*, 66 Or App 135, 673 P2d 558 (1983), where we held that a claimant could recover interim compensation, although she continued to work.[2] Both parties requested

[1] ORS 656.313 provides:

"(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant.

"(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal.

"* * * * *

"(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."

[2] In *Bono*, we stated that interim compensation is

"primarily to induce insurers to deny a claim promptly or be required to pay interim compensation, regardless of the validity of the claim. It is not really payment for a compensable loss; *its function is to protect a claimant against unreasonable delay in processing the claim.*" 66 Or App at 143. (Emphasis supplied.)

(1981), we held that ORS 656.386(1)[1] and ORS 656.388(2),[2] which provide for circuit court review of attorney fees awards under certain circumstances, are not the exclusive method of obtaining review of a referee's attorney fees award but, rather, are an alternative to the normal Board review. In *Farmers Ins. Group v. SAIF*, 301 Or 612, 619, 724 P2d 799 (1986), the Supreme Court stated, in *dictum*, that "any disagreement regarding the amount of attorney fees awarded by a referee is not subject to the ordinary board review procedures of ORS 656.295, but is to be resolved [by the circuit court] under the unique provisions of ORS 656.388(2)." Because the Supreme

Court's statement is *dictum*, it does not, as claimant seems to assume, directly overrule our holding in *Anlauf*. However, it, a subsequent amendment to that statute and the need to consider another statute which we did not mention in *Anlauf* do justify another examination of the subject. That reexamination leads us to modify our previous holding.

We begin with the original purposes of ORS 656.386(1) and ORS 656.388(2). The legislature adopted earlier versions of them, before the creation of the present workers' compensation system in 1965. At the time, all covered employers had to insure with the State Industrial Accident Commission (SIAC). SIAC conducted hearings and issued final orders awarding or denying compensation. A claimant could appeal from a SIAC award to the circuit court; the employer was neither an interested party nor a participant in the proceedings before SIAC or in court. *See former* ORS 656.272 to ORS 656.290 (*repealed or amended by* Or Laws 1965, ch 285, § 95). Thus, only SIAC and the claimant or the claimant's attorney were interested in the amount of the attorney fees.

Before 1951, SIAC was only authorized to allow a fee to be paid from a claimant's compensation award. ORS 656.388(1) (formerly ORS 656.590(1)) is the current version of that statute; intervening amendments have not made any relevant changes. An attorney who was dissatisfied with the award could seek immediate circuit court review of the award without having to appeal the entire case. *Former* ORS

[1] 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. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be set as provided for in ORS 656.388 (2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

An occupational disease is effectively treated as an injury under the Workers' Compensation Act. ORS 656.804.

[2] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

656.590(2) (now ORS 656.388(2)). In 1951, the legislature required SIAC to pay attorney fees in addition to, rather than out of, compensation when a claimant successfully appealed SIAC's rejection of a claim. Or Laws 1951, ch 330, § 2 (codified as ORS 656.588; now ORS 656.386).[3] A 1957 amendment,

Oregon Laws 1957, ch 558, § 1,[4] also required SIAC-paid fees in cases where the claimant prevailed on appeal to the Commission from a hearings officer and provided that disputes over the amount of the fees would go to circuit court under the same procedures as if the fees came from the compensation award.

In short, circuit court review of fee disputes began as a streamlined method of bringing the issue to the court which had appellate jurisdiction over SIAC orders in cases where the merits were no longer contested. Because SIAC both adjudicated claims and administered the fund from which they were paid, it had an apparent conflict in deciding attorney fees questions. The procedure was designed to overcome that conflict. When the legislature abolished SIAC in 1965 and created the Workers' Compensation Board as a purely adjudicative body, it retained the previous rights to attorney fees and the previous procedure for resolving disputes concerning them, simply giving formal recognition to the role of the hearings officer (presently known as the referee). Or Laws 1965, ch 285, §§ 42a, 42b (*amending* ORS 656.588 and ORS 656.590 (now ORS 656.386 and ORS 656.388)). Neither then nor since has the legislature explicitly provided for an *employer* to seek review of a fee award. Much of the statutory language, read literally, makes sense only in the context of the pre-1965 compensation system. The statutes can, however, be read in a fashion which is compatible with the present system.

Before making that reading, we note an additional relevant provision which neither party mentions. The 1965 legislature was concerned that, under the new system, an insurer might have an incentive to fight claims from one level to another, hoping that the claimant would eventually give up.

---

[3] Or Laws 1951, ch 330, § 2, provides:

"In all cases involving accidental injuries occurring on or after July 1, 1951, where an injured workman prevails in an appeal to the circuit court from a commission order rejecting his original claim for compensation, the commission shall allow a reasonable attorney fee to the claimant's attorney, which said attorney fee shall be paid from the Industrial Accident Fund as an administrative expense. In all other cases attorney fees shall continue to be paid from the claimant's award of compensation."

[4] Or Laws 1957, ch 558, § 1, amended *former* ORS 656.588(1) (now ORS 656.386(1)) to provide:

"In all cases involving accidental injuries occurring on or after July 1, 1957, where a claimant prevails in an appeal to the circuit court from a commission order rejecting his original claim for compensation, the court shall allow a reasonable attorney's fee to the claimant's attorney. In such rejected cases where the claimant prevails in his appeal before the commission itself, then the commission shall allow a reasonable attorney's fee; however, in the event a dispute arises as to the amount allowed by the commission, that amount may be settled as provided for in subsection (2) of ORS 656.590 [now ORS 656.388(2)]. Attorney fees provided for in this section shall be paid from the Industrial Accident Fund as an administrative expense."

It therefore adopted ORS 656.382(2),[5] requiring an employer or insurer to pay the claimant's attorney fee in all cases if it initiated the review and lost on the merits. *See Bracke v. Baza'r*, 294 Or 483, 487-488, 658 P2d 1158 (1983). That statute is the *sole* basis for an award of attorney fees when an *employer* initiates the review. *Shoulders v. SAIF*, 300 Or 606, 716 P2d 751 (1986). It does not provide for disputes to be resolved in the circuit court by the procedure established in ORS 656.388(2), which can apply *only* when the claimant has initiated the most recent level of review.

ORS 656.386(1) allows a referee to award attorney fees in denied cases "where the claimant *prevails finally* in a hearing before the referee * * *." (Emphasis supplied.) If the claimant "prevails finally" before the Board, then it sets the fee. If the referee rules in favor of a claimant and the employer seeks Board review of compensability, the claimant has not prevailed finally before the referee; that does not occur until the review process is completed favorably to the claimant. Thus the referee's fee award is only tentative; like the rest of the referee's order, the Board may "affirm, reverse, modify or supplement" it. ORS 656.295(6). When the employer seeks review of compensability, the attorney fees provisions of ORS 656.386(1) no longer apply and neither do the provisions of ORS 656.388(2). The Board has the sole authority to set the attorney fees in that circumstance, subject to appellate review.[6]

If, however, the employer accepts the referee's compensability decision and contests only the fees award, the situation is different. ORS 656.386(1) presently provides, in

part, "[i]n the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount *shall* be set as provided for in ORS 656.388(2)." (Emphasis supplied.) At the time of our decision in *SAIF v. Anlauf, supra*, the statute read "that amount *may* be settled as provided for in subsection (2) of ORS 656.388." (Emphasis supplied.) We relied on the word "may" in holding that the procedure was not exclusive. 52 Or App at 119. The 1983 legislature changed "may" to "shall." Or Laws 1983, ch 568, § 2. The only apparent reason for the amendment was to make the procedure a requirement instead of an alternative. Thus, when a referee's decision is the final determination of the compensability of a denied claim, the *only* way to obtain review of the attorney fees award is through the circuit court procedure under ORS

[5] ORS 656.382(2) presently provides:

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

[6] When the Board affirms a finding of compensability, the award for services at the hearing before the referee is no longer the referee's award under ORS 656.386(1). The Board's adoption or modification of it makes it an award *by the Board* under ORS 656.382(2) for "legal representation by an attorney for the claimant at *and prior to*" the Board's review. (Emphasis supplied.)

656.388(2).[7] We overrule *SAIF v. Anlauf, supra,* to the extent that it is inconsistent with these conclusions.

ORS 656.388(2) provides that, if an attorney and the referee or Board cannot agree on the amount of the fees, each shall submit "a written statement of the services rendered" to the circuit court. That language assumes that the attorney involved is the claimant's attorney; in the pre-1965 context that was an appropriate assumption. However, it does not foreclose an employer's attorney from initiating the process; the claimant would then be entitled to participate in it. We held in *SAIF v. Huggins,* 52 Or App 121, 627 P2d 1272 (1981), that the procedure is available to either party, and we adhere to that holding. The legislature simply neglected to modify language which became outdated with the change in the system in 1965.

Because in this case employer sought Board review of the referee's compensability determination, the Board had jurisdiction to review the attorney fee award. Claimant does not attack the Board's action on the merits. We therefore affirm the Board.

Affirmed.

[7] Similarly, if the claimant is dissatisfied with the referee's fee award and the employer seeks Board review of compensability, the claimant may then obtain Board review of the fees award. *See* ORS 656.289(3). If the employer does not seek Board review of compensability, the claimant has prevailed finally before the referee and must take the dispute to circuit court.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Marvin L. Noffsinger, Claimant.

NOFFSINGER,
Petitioner,

v.

YONCALLA TIMBER PRODUCTS et al,
Respondents.

(WCB 84-12362; CA A38416)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Darrell E. Bewley, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's denial of temporary disability benefits. We affirm.

Claimant was employed as a millworker at Yoncalla Timber. He testified that for a period of approximately two years he had been experiencing "mental stress" due to pressure and harassment at work. On April 11, 1984, he was fired. The following day he saw Dr. Wiltse for symptoms related to stress. On April 24, Wiltse filled out a form releasing claimant for "regular work" but indicating that he was not medically stationary. Wiltse explained in a letter that he was in favor of claimant's working, but not at Yoncalla. Within two weeks of claimant's discharge, he applied for unemployment benefits, which he began receiving.[1]

On May 14, 1984, claimant filed a claim for occupational stress, which we upheld on review. *SAIF v. Noffsinger*, 80 Or App 640, 723 P2d 358, *rev den* 302 Or 342 (1986). SAIF accepted the claim as nondisabling in March, 1985, and has refused to pay any temporary disability compensation. Claimant contends that he is entitled to temporary disability benefits, because he was not medically stationary and because Wiltse's release did not constitute a release to return to "regular work." SAIF argues that claimant is not entitled to temporary disability because he was released for "regular work."

Both parties focus on the provisions of ORS 656.268, which govern the termination of temporary disability compensation. That statute provides that "[c]laims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary * * *." ORS 656.268(1). Subsection (2) states:

> "When the injured worker's condition resulting from a *disabling injury* has become medically stationary, unless the injured worker is enrolled and actively engaged in training, the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if

> any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the Evaluation Division and to the worker and to the employer, if requested by the worker or employer. If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section. If the attending physician has approved the worker's return to the worker's regular employment and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of any vocational assistance provided by this chapter." (Emphasis supplied.)

ORS 656.268 deals with the termination of benefits

[1] Claimant's request for temporary total disability is inconsistent with his claim for unemployment benefits. *See Wells v. Pete Walker's Auto Body*, 86 Or App 739, 740 P2d 245 (1987).

for, or the closure of, a claim which has previously been accepted as disabling. Here, SAIF has never paid temporary total disability benefits and has never acknowledged that the claim is disabling. Even so, SAIF relies on the language of ORS 656.286(2) for its statement that temporary total disability benefits may be terminated when a claimant has been released for regular employment. Although that factor may be relevant to a determination of whether a claimant is disabled, the statute itself does not resolve the present problem.

The direct question presented is whether claimant is or has ever been disabled from work as a result of his compensable stress claim. As recognized by the Supreme Court in *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985), the entire scheme of the Workers' Compensation Law is to compensate workers "for wages lost because of inability (or reduced capacity) to work as a result of a compensable injury." Claimant's doctor released him for "regular work," including the millwork that he had done before, but recommended that he not return to Yoncalla because of his reaction to stress peculiar to that work place. The evidence establishes that claimant left work at Yoncalla because he was fired, not because he was disabled. He is not precluded from working for any other employer. We conclude that he has not lost wages because of an inability to work as a result of his compensable condition and that, therefore, he is not entitled to temporary disability benefits.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Margie M. Guill, Claimant.

GUILL,
Petitioner,

v.

PENDLETON WOOLEN MILLS,
Respondent.

(WCB No. 85-09065; CA A42368)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 6, 1987.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Mildred J. Carmack, Portland, argued the cause for respondent. With her on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant prevailed before the referee in establishing the compensability of her injury claim. Employer appealed to the Workers' Compensation Board, which affirmed the referee on compensability but reduced the fee which the referee had awarded claimant's attorney. Claimant seeks judicial review of that action. She argues, first, that jurisdiction to modify a referee's attorney fees award is solely in the circuit court under ORS 656.386(1) and ORS 656.388(2). Because employer sought Board review of compensability, claimant is wrong. *Greenslitt v. City of Lake Oswego*, 88 Or App 94, ___ P2d ___ (1987). On *de novo* review, we find no reason to disturb the Board's decision.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Carolyn K. Barr, Claimant.

BARR,
Petitioner - Cross-Respondent,
v.
EBI COMPANIES et al,
Respondents - Cross-Petitioners,
and
SAIF CORPORATION et al,
Respondents.

(WCB 84-04731, WCB 85-05501; CA A40548)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 10, 1987.

Lawrence B. Rew, Pendleton, argued the cause for petitioner - cross-respondent. With him on the brief was Corey, Byler, Rew, Lorenzen & Hojem, Pendleton.

Jerald P. Keene, Portland, argued the cause for respondents - cross-petitioners EBI Companies and Villa Royal Health Care. With him on the brief was Roberts, Reinisch & Klor, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Amber Valley Care Center. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Affirmed.

WARDEN, P. J.

Claimant petitions for review of a Workers' Compensation Board order that affirmed the referee's order denying benefits. The Board agreed with the referee that claimant's initial hearing request on EBI's denial was premature and that she had failed to establish good cause for her untimely second hearing request. We affirm.[1]

Claimant sustained a compensable injury while working for Villa Royal Health Care, EBI's insured, in March, 1979. In January, 1984, claimant became disabled while working for SAIF's insured. She filed a claim for occupational disease, which SAIF denied.

On February 24, 1984, claimant mailed EBI notice of a claim for aggravation of her 1979 injury. EBI received it on February 27. Claimant filed a request for hearing on April 26, 59 days after EBI had received the claim and 62 days after claimant had mailed the notice of claim. EBI denied the claim on May 7. Claimant filed another request for hearing on July 12, more than 60, but fewer than 180, days after EBI's denial.

On review, claimant contends that the Board erred in dismissing her claim, arguing that her first hearing request was not premature and that she had shown good cause for the untimely filing of her second hearing request. We first address the issue of the prematurity of the April hearing request.

In order to obtain medical services or disability compensation on an aggravation claim, a claimant must "file" the claim with the insurer or self-insured employer, ORS 656.273(2), which must accept or deny it within 60 days after "notice or knowledge of the claim," ORS 656.262(6), or risk imposition of penalties and the assessment of attorney fees. ORS 656.262(10); ORS 656.382. A claim is deemed denied *de facto* after expiration of the 60-day period, if the insurer or self-insured employer has not accepted or denied it. *Syphers v. K-W Logging, Inc.*, 51 Or App 769, 771, 627 P2d 24, *rev den* 291 Or 151 (1981). A claimant may request a hearing on a denial within 60 days after either "the mailing of the notice of denial," ORS 656.262(8), or the *de facto* denial. *Syphers v.*

K-W Logging, Inc., supra. A premature request for a hearing on the issue of whether a claim should be accepted is ineffective and void. *Syphers v. K-W Logging, Inc., supra.*

Claimant equates EBI's "notice or knowledge" of her aggravation claim with her mailing of the notice of that claim and would compute the 60-day period during which EBI had to accept or deny it as beginning on the date of that mailing. By that computation, her April 26, 1984, request for hearing would not be premature. She relies on *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), and *Madewell v. Salvation Army*, 49 Or App 713, 620 P2d 953 (1980). Those cases, however, are not helpful to her, and she overlooks *Bergeron v. Ontario Rendering Co.*, 34 Or App 1025, 580 P2d 216, *rev den* 284 Or 80 (1978), in concluding that they are helpful.

[1] At oral argument claimant abandoned her petition as to SAIF and Amber Valley Care Center, its insured, and we therefore affirm as to those respondents also. Because we affirm on the petition, we need not address EBI's cross-petition.

By analogy, *Norton* supports EBI's position, rather than claimant's. *Norton* involved the timeliness of a request for hearing *after* the claimant had received notice that his claim had been denied. The request was received 61 days after the date of mailing of the denial but only 60 days after its receipt by the claimant. ORS 656.262(6), as it then read, provided: "The workman may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial."[2] ORS 656.319(2)(a) then provided:

> "With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless a request for hearing is filed within 60 days after the claimant was notified of the denial."

Although the claimant had mailed the request for hearing within 60 days of his receipt of the denial, because it was received, *i.e.*, was filed, *more than* 60 days after the denial was mailed, the Supreme Court held the request to be untimely.[3]

Here the request for hearing was received by EBI *less* than 60 days after the claim for aggravation was filed.

In *Madewell,* we treated the claimant's request for hearing as timely, because the employer offered no proof of the date of mailing of the letter denying the claim. Here, there is no issue as to the date of the denial.

ORS 656.273, which deals specifically with aggravation claims, repeatedly states that such claims must be "filed" with the insurer or self-insured employer. "Filing" has been held to mean receipt. *See Bergeron v. Ontario Rendering Co., supra.* ORS 656.273(6) provides:

> "A claim submitted in accordance with [ORS 656.273] shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262 * * *."

That language expressly premises application of the processing provisions of ORS 656.262 to whether an aggravation claim was filed pursuant to ORS 656.273. It follows that, because "filing" means receipt, the "notice or knowledge" language in ORS 656.262 must be equated with an insurer's *receipt* of the claim. Because claimant initially requested a hearing fewer than 60 days after EBI had "notice or knowledge" of the claim, that request was premature and, therefore, void. *Syphers v. K-W Logging, Inc., supra.*

Claimant's second hearing request was filed more than 60, but fewer than 180, days after EBI's denial. ORS

[2] That language now appears in ORS 656.262(8).

[3] In *Bergeron v. Ontario Rendering Co., supra,* the claimant sought review of a determination order that was *mailed* on October 8, 1975. On October 6, 1976, claimant *mailed* a request for a hearing, but it was not received by the Board until October 11, more than a year after the date on which the determination order had been mailed. We applied the holding in *Norton:*

> "Claimant argues that under ORS 656.383(2), the mailing of the request [for a hearing] within the one-year period was sufficient. In *Norton v. Compensation Department,* [*supra,*] the court was faced with essentially the same issue. In that case claimant's request for a hearing was mailed within the period provided by ORS 656.319(1)(a), but was not received by the Board until after the period had expired. The request was held untimely." 34 Or App at 1027. (Footnotes omitted.)

We upheld the Board's conclusion that the filing was untimely.

656.319(1) provides:

> "(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:
>
> "(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or
>
> "(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

"Good cause" in subsection (b) has been held to be the equivalent of "mistake, inadvertence, surprise or excusable neglect" in *former* ORS 18.160.[4] *Sekermestrovich v. SAIF*, 280 Or 723, 727, 573 P2d 275 (1977).

Claimant contends that she had good cause for the untimely filing of the second hearing request, because it was not unreasonable and because no appellate court had previously decided whether the mailing of a claim to an insurer constitutes "notice or knowledge" of the insurer as to that claim under ORS 656.262(6). We disagree. Under the holding in *Syphers v. K-W Logging, Inc., supra*, she was on notice that a premature hearing request on the issue of whether a claim should be accepted is ineffective and void. If she had any doubt as to whether her initial hearing request was premature, she could have filed a formal and timely protective request for a hearing on EBI's denial. She neglected to do that, and because she has provided no valid excuse for not doing so, she has failed to demonstrate good cause.

Affirmed.

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[4] *Former* ORS 18.160, which was repealed by Or Laws 1981, ch 898, § 53, and replaced by ORCP 71B, effective January 1, 1982, provided, in pertinent part:

> "The court may, in its discretion, and upon such terms as may be just, at any time within one year after notice thereof, relieve a party from a judgment, decree, order or other proceeding taken against him through his mistake, inadvertence, surprise or excusable neglect."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dena M. Smith, Claimant.

SMITH,
Petitioner,

v.

RIDGEPINE, INC. et al,
Respondents.

(WCB 85-05567; CA A41505)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 11, 1987.

J. Michael Casey, Portland, argued the cause for petitioner. With him on the brief was Doblie & Associates, Portland.

Patric J. Doherty, Portland, argued the cause for respondents. With him on the brief were Ronald W. Atwood and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Affirmed.

WARDEN, P. J.

In this workers' compensation case, claimant seeks review of a Board order which affirmed the referee's holding that claimant is not entitled to temporary total disability (TTD) benefits. We affirm.

Claimant sustained a low back injury on February 8, 1980. She saw Dr. Fredstrom that day and again 10 days later, when he found her to be asymptomatic except for pain that she claimed to experience when doing heavy lifting. United Pacific Insurance accepted her claim as nondisabling, and she did not contest that. ORS 656.262(6). She received further treatment for her low back injury in 1983, and then that treatment was apparently billed to and paid by United.

A letter from Dr. Kovachevich, dated February 11, 1985, was claimant's first claim for TTD benefits. The referee determined that the claim was barred under *former* ORS 656.262(10) (*now* ORS 656.262(12)) and ORS 656.273(4)(b), because it was filed more than five years after the 1980 nondisabling injury. The Board affirmed on the ground that claimant had removed herself from the workforce in 1983. We affirm on the ground stated by the referee.

At the time of claimant's initial injury in 1980, ORS 656.262(10) provided, in pertinent part:

"A claim that a nondisabling injury has become disabling,

if made more than one year after the date of injury, *shall be made pursuant to ORS 656.273 as a claim for aggravation.*" (Emphasis supplied.)

At the same time, ORS 656.273(4) provided, in pertinent part:

"(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under [ORS 656.268(3)].

"(b) If the injury was nondisabling and no determination was made, the claim for aggravation *must be filed within five years after the date of injury.*" (Emphasis supplied.)

Claimant's claim must be treated as an aggravation claim under ORS 656.273, because it was made on the basis that her previously nondisabling injury had become disabling more than one year after the date of injury. The insurer first

received notice of the claim on February 19, 1985, by Kovachevich's letter of February 11, 1985. It follows that the claim is barred, because claimant did not file it within five years of her injury.

Affirmed.[1]

[1] The Board affirmed the referee's awards to claimant for medical services and attorney fees, and those awards are not challenged by either employer or insurer.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

McGAUGHEY et al,
Appellants,
v.
ST. PAUL FIRE AND MARINE INSURANCE COMPANY,
Respondent.

(85-C-614752; CA A42702)

Appeal from District Court, Multnomah County.

Robert L. Kirkman, Judge.

Argued and submitted September 11, 1987.

Richard S. Yugler, Portland, argued the cause and filed the brief for appellants.

Paul Silver, Portland, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

This is an action for breach of a comprehensive general liability insurance contract issued by defendant to plain-

tiffs, who seek to recover the cost of defending a workers' compensation claim. The claim was filed by plaintiffs' former employe. Plaintiffs tendered defense of the claim, and defendant refused the tender. The trial court held that, under the terms of the insurance contract, defendant had no duty to defend. Plaintiffs appeal, and we affirm.

Plaintiffs own and operate a trailer park. They hired Mrs. Sauer to manage the park, and she lived in a house located there. On April 16, 1985, she was fired as manager, but she was allowed to remain in the house until May 1. On April 22, she broke her leg at the park. She filed a workers' compensation claim, which was denied. She requested a hearing. Plaintiffs tendered the defense of the claim to defendant, which rejected it on the ground that the insurance contract excludes coverage of workers' compensation claims. The hearings referee ruled that Sauer's claim was not compensable under the workers' compensation law, because she was not a covered worker.

The procedural posture of this case is murky and requires explanation. Defendant filed an amended answer admitting the material factual allegations of the complaint, and denying, *inter alia,* that it breached the insurance contract when it rejected the tender. At trial, plaintiffs argued that the trial court should first decide whether the contract, which was attached to the complaint, was ambiguous. If it was, a jury would have to decide the factual issue. If the contract was not ambiguous, then there were only legal issues, which the court would decide. The trial court agreed and decided that the contract is not ambiguous and that defendant did not breach it "by refusing to provide a defense to the Workers' Compensation claim" and entered judgment for defendant.

Plaintiffs contend that the exclusionary clause in the contract is ambiguous. Whether the clause is ambiguous is a question of law. *Adams v. Northwest Farm Bureau Ins.,* 40 Or App 159, 164, 594 P2d 1256, *rev den* 287 Or 123 (1979). Words or terms in an insurance contract are ambiguous when "they could reasonably be given a broader or a narrower meaning, depending upon the intention of the parties in the context in

which such words are used by them." *Shadbolt v. Farmers Insur. Exch.,* 275 Or 407, 551 P2d 478 (1976). The allegedly ambiguous language must be reasonably susceptible of more than one meaning. *Western Fire Insurance Co. v. Wallis,* 289 Or 303, 308, 613 P2d 36 (1980). Language not reasonably susceptible of more than one meaning should not be rendered ambiguous "by attributing possible but unlikely meanings to the terms employed without some basis in the policy for doing so." 289 Or at 308. If an insurance contract is ambiguous, the meaning of the ambiguous term is a question of fact. *A-1 Sandblasting v. Baiden,* 53 Or App 890, 893, 632 P2d 1377 (1981), *aff'd* 293 Or 17 (1982).

The relevant clauses of the insurance contract provide:

"WHAT THIS AGREEMENT COVERS

"* * * * *

"**Defending lawsuits.** We'll defend any suit brought against you or any other protected person for covered claims, even if the suit is groundless or fraudulent. * * *

"EXCLUSIONS - CLAIMS WE WON'T COVER

"**Workers Compensation.** We won't cover obligations that protected persons or their insurance companies have under workers compensation, unemployment compensation, disability benefits or similar laws." (Emphasis in original.)

The contract is not ambiguous. Defendants had a duty to defend *any covered claim*, even if groundless. By the clear terms of the contract, workers' compensation claims are "claims we won't cover." Defendant had no duty to defend, because the claim filed by Sauer with the Workers' Compensation Department was not a covered claim as defined by the contract. A reasonably intelligent and careful person in the position of plaintiffs could not have understood the contract to mean anything else. *State Farm Mutual Auto. Ins. Co. v. White*, 60 Or App 666, 672, 655 P2d 599, *rev den* 294 Or 569 (1983).

Affirmed.[1]

[1] In view of this disposition, we need not consider plaintiffs' other assignments of error.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth Dalgliesh, Claimant.

DALGLIESH,
Petitioner,

v.

SCOTT et al,
Respondents.

(WCB 84-08363; CA A40624)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs March 25, 1987.

Charles Robinowitz, Portland, filed the briefs for petitioner.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and John A. Reuling, Jr., Assistant Attorney General, Salem, filed the brief for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed as modified.

PER CURIAM

Claimant challenges an award of permanent partial disability. On *de novo* review, we affirm the Board's award as to claimant's left leg and right shoulder and modify the order to award claimant permanent partial disability to the extent of 75 percent for his right arm.

Affirmed as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lee E. Short, Claimant.

SHORT,
Respondent,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Appellants.

(A8606-03219; CA A41221)

Appeal from Circuit Court, Multnomah County.

Charles S. Crookham, Judge.

Argued and submitted May 8, 1987.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for Appellants. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Richard A. Sly, Portland, argued the cause for respondent. With him on the brief was Bloom, Marandas & Sly, Portland.

Before Buttler, Presiding Judge, and Rossman and Deits, Judges.

BUTTLER, P. J.

Reversed.

BUTTLER, P. J.

SAIF appeals from a judgment of the circuit court entered pursuant to ORS 656.388(2) requiring it to pay attorney fees in addition to the amount previously ordered by the Workers' Compensation Board and approved by this court on review. The question is whether the circuit court had the authority to revise the amount of fees ordered by the Board when the insurer initiated Board review. We hold that it did not and, therefore, reverse.

Claimant suffered a compensable injury on February 1, 1977, when she fell down a flight of stairs and struck her head. Her claim was closed in July, 1979, and she was awarded 35 percent unscheduled disability for her neck and "mild psychological conditions." In September, 1982, she requested a reopening of her claim on the basis of a newly diagnosed organic brain injury. SAIF denied the request, and a hearing was held on January 5, 1984; the referee ordered that the claim be reopened as of September 29, 1982, imposed a penalty on SAIF for unreasonable delay in denying the claim and in paying interim compensation and awarded attorney fees of $500 in connection with the penalty issues and $2,000 on reversal of the denial.

SAIF appealed to the Board, arguing that claimant's newly diagnosed condition was not compensable and, in the

alternative, that a later reopening date was appropriate. Claimant filed a cross-appeal, contending that the reopening date should be earlier than that ordered by the referee. On February 13, 1985, the Board modified the referee's order, delaying the reopening date to March 30, 1983. The penalty and associated attorney fees were reduced. The attorney fee for prevailing on the denied claim was increased to $3,750 and an additional fee of $750 was awarded on the Board review.

Claimant petitioned this court for review and assigned error to, among other things, the amount of attorney fees awarded by the Board. We modified the Board's order as to the date of reopening, holding that September 1, 1982, was the proper date. We reinstated the referee's order regarding the penalty issue and affirmed the Board's award of attorney fees:

"Finally, we affirm the Board's award of attorney fees for

prevailing on SAIF's denial. The Board considered all of the evidence submitted by claimant's attorney and increased the fee awarded by the referee to $3,750, finding that an extraordinary fee was warranted. The Board also awarded $750 for services on Board review. On claimant's motion for reconsideration, the Board declined to increase the attorney fees award. The award does not appear to be unreasonable, and we defer to the Board in the light of its frequent determinations in this area; it may be expected to make consistent and knowledgeable assessments of the attorney effort involved." *Short v. SAIF*, 79 Or App 423, 429, 719 P2d 894 (1986).

Shortly after that decision, claimant petitioned the circuit court for an increase in the fees award, pursuant to ORS 656.388(2), which then provided:

"If an attorney and the referee or board or appellate court cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge of the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

The circuit court raised the fees award to $12,000 and ordered SAIF to pay that amount, less $4,750 that it had already paid. SAIF appeals, arguing that the court lacked jurisdiction to adjust the award and, in the alternative, that the fees that it awarded were excessive.

Claimant argues that her right to recover attorney fees stems from ORS 656.386(1),[1] which allows either party to contest fees in circuit court by the procedure provided in ORS 656.388(2). ORS 656.386(1) provides for insurer-paid attorney fees when the claimant has prevailed finally on an appeal from

[1] At the relevant time, ORS 656.386(1) provided:

"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. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

an order or decision denying the claim. In this case, the referee had determined that the claim should be reopened; he did not deny the claim. Employer sought Board review, and claimant prevailed *finally* on compensability before the Board. Because claimant did not prevail finally before the referee, her attorney fees could not be awarded pursuant to ORS 656.386(1). SAIF sought Board review of the referee's order, and attorney fees were awarded pursuant to ORS 656.382(2),[2] which is the sole basis for an award of employer paid fees when an employer initiates the final review process. *Shoulders v. SAIF*, 300 Or 606, 615, 716 P2d 651 (1986); *Greenslitt v. City of Lake Oswego*, 88 Or App 94, ___ P2d ___ (1987). That statute does not provide for circuit court review of attorney fees. Accordingly, there was no statutory basis for the circuit court to review the fees awarded by the Board in this case.

Reversed.

[2] At the relevant time, ORS 656.382(2) provided:

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

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wesley E. Crooke, Claimant.

CROOKE,
Petitioner - Cross-Respondent,
v.
GRESHAM TRANSFER et al,
Respondents - Cross-Petitioners.

(WCB 83-11486; CA A40340)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 3, 1987.

Linda C. Love, Portland, argued the cause for petitioner - cross-respondent. On the brief were James L. Francesconi and Francesconi & Cash, P.C., Portland.

Bruce L. Byerly, Portland, argued the cause for respondents - cross-petitioners. With him on the brief was Moscato & Byerly, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

On petition, referee's order reinstated; affirmed on cross-petition.

WARREN, J.

In this workers' compensation case, claimant seeks review of the Board's decision reversing the referee in part and holding that his psychologist could not provide medical verification of inability to work. Employer cross-petitions, seeking a determination that claimant's aggravation claim for a psychological condition and globus syndrome (a choked up feeling in the throat) is not compensable. We affirm on the cross-petition and write only to address the issue raised by claimant.

Claimant worked for employer as a truck driver until 1980, when he injured his arm on the job. Through vocational rehabilitation he obtained employment as a painter in July 1983 but was laid off in December 1983 due to a lack of work. He has not been able to find work since that time.

He was referred by his attorney to Drs. Colistro and Bowes in December 1983 for evaluation of globus syndrome and depression. At the time, Colistro was a psychologist licensed by the State Board of Psychologist Examiners. ORS 675.030. Bowes was a resident psychologist entitled to work under the supervision of a licensed practitioner. On April 26, 1984, Colistro and Bowes wrote a letter to claimant's attorney, stating that claimant would not be "ready to assume the demands of a new job" until he had undergone psychological counseling. The Board ultimately determined that claimant's globus and psychological conditions, claims for which had been denied by employer, were compensable but reversed the referee in part holding that claimant was not entitled to temporary disability because there had been no medical verification by one authorized to give it that claimant was unable to work.

ORS 656.273(6) provides, in part:

> "[T]he first installment of compensation due under ORS 656.262(4) shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition."

The statutes do not discuss who is authorized to provide medical verification so as to trigger an employer's obligation to begin paying interim compensation on an aggravation claim.

We conclude, however, that the answer can be ascertained from the legislative history.

Until 1975, ORS 656.273(4) required that a claim for aggravation "be supported by a written opinion of a physician that there are reasonable grounds for the claim." The legislature deleted that subsection and added present subsection (3), which states that "[a] physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." Or Laws 1975, ch 497, § 1. Thus, the section no longer precludes the making of an aggravation claim without a supporting medical opinion. At the same time, the legislature added subsection (6), which establishes the requirement for medical verification of time loss. Thus, the

legislature altered the substantive prerequisites for an aggravation claim, deleting the *requirement* of a physician's report; however, it retained the element of medical documentation with respect to time loss. There is no reason to doubt that the legislature intended that that documentation come from a "physician," as required under the pre-1975 version of ORS 656.273(4) and as is presently permitted by ORS 656.273(3), and we conclude that it must.

ORS 656.005(13) defines "physician," for purposes of workers' compensation, as "a person duly licensed to practice one or more of the healing arts." This case turns, therefore, on whether the practice of psychology is a healing art. Psychologists must be licensed to practice and are subject to regulation and discipline by the State Board of Psychologist Examiners. ORS 675.100. The "practice of psychology" is defined, in part, as

> "the diagnosis, prevention, treatment and amelioration of psychological problems and emotions and mental disorders of individuals and groups." ORS 675.010(4).

The scope of the practice of psychology certainly encompasses elements which are considered to be "healing." Although it has nowhere directly described psychology as a healing art, the legislature has impliedly viewed it as one in ORS 675.090(4), which defines those who are not subject to the regulation of the State Board of Psychologist Examiners to include "[a]ny person licensed to practice one or more of *the other healing arts* in the state of Oregon so long as the person does not apply

either of the specific terms of 'psychologist' or 'psychometrist' to that person's practice." (Emphasis supplied.)

We conclude that psychologists practice one of the healing arts as the term is used in ORS 656.005(13) and that they are therefore capable of providing medical verification of an inability to work as required by ORS 656.273. We held, on *de novo* review, that Colistro's report of April 26, 1984, stating that claimant "would not be ready to assume the demands of a new job" until he had undergone psychological counseling, was medical verification of an inability to work as of that date.

On petition, referee's order reinstated; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Terry L. Hunter, Claimant.

HUNTER,
Petitioner,

v.

TELEDYNE WAH CHANG et al,
Respondents.

(WCB No. 84-13275; CA A39205)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Bradley R. Scheminske, Portland, argued the cause for respondents. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed; referee's order reinstated.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee's order requiring insurer to pay "interim compensation" pending Board review of an earlier referee's decision awarding interim compensation. ORS 656.313.[1] We reverse.

Claimant requested a hearing on employer's denial of his occupational disease claim. The referee upheld the denial but awarded interim compensation, relying on our decision in *Bono v. SAIF,* 66 Or App 135, 673 P2d 558 (1983), where we held that a claimant could recover interim compensation, although she continued to work.[2] Both parties requested

[1] ORS 656.313 provides:

"(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant.

"(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal.

"* * * * *

"(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."

[2] In *Bono,* we stated that interim compensation is

"primarily to induce insurers to deny a claim promptly or be required to pay interim compensation, regardless of the validity of the claim. It is not really payment for a compensable loss; *its function is to protect a claimant against unreasonable delay in processing the claim.*" 66 Or App at 143. (Emphasis supplied.)

Board review of the order. Pending review, insurer refused to pay interim compensation. Claimant requested a second hearing on that refusal.

The Supreme Court then decided *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), in which it reversed this court and held that a claimant could not recover interim compensation if he had no time loss. Following the Supreme Court's decision, the Board reversed the first referee's award of interim compensation, because claimant had no time loss due to an occupational disease.

The second referee then ruled that, regardless of

Bono and the Board's decision, insurer must pay interim compensation. Insurer sought review, and the Board again reversed. The Board erred. *Georgia Pacific v. Hughes,* 85 Or App 362, 736 P2d 602, *rev allowed* 304 Or 55 (1987).

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Russell Miller, Claimant.

WEYERHAEUSER COMPANY,
Petitioner,
v.
MILLER,
Respondent.

(WCB 84-13597; CA A39349)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1986.

Paul J. DeMuniz, Salem, argued the cause for petitioner. With him on the brief was Garrett, Seideman, Hemann, Robertson & DeMuniz, P. C., Salem.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief was Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded.

Richardson, P. J., dissenting.

DEITS, J.

Employer seeks review of an order of the Workers' Compensation Board which dismissed its request for review for lack of jurisdiction. The referee's order was mailed to the parties on September 27, 1985. In February 1986, the attorney

for employer asked the Board about the status of the request for review, which he claimed had been mailed on October 14, 1985. The Board dismissed the appeal, because the Board had not received the request and employer had not submitted the required proof of mailing. The Board said:

> "We recently decided that when there is a question regarding whether a request for Board review was timely mailed to the Board, proof of such mailing must conform to the requirements of OAR 438-05-040(4)(b)."

ORS 656.295(2) requires that a request for review of a referee's order "shall be mailed to the board * * *." The Board adopted OAR 438-05-040(4)(b), which provides, in material part:

> " 'Filing' means:
>
> "* * * * *
>
> "(b) date of mailing. If the date of mailing is relied upon as the date of filing, there must be proof from the post office of the mailing date. Acceptable proof from the post office shall be a receipt stamped by the post office showing the date mailed and the certified or registered number."

Employer argues that, if OAR 438-05-040(4)(b) is applicable, the Board exceeded its authority in adopting the rule.[1] We agree. Although an agency may adopt a rule to carry out provisions of enabling legislation, it may not by rule amend, alter, enlarge or limit the terms of statutes. *Oreg. Fire/Police Retire. v. PERB*, 62 Or App 777, 662 P2d 729 (1983). All that the statute requires to perfect review before the Board is the mailing of a request for review. The statute requires neither actual receipt nor a particular method of mailing.

We recognize that the Board does have general rulemaking authority:

> "The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. Such rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings." ORS 656.726(4).

That statute allows the Board to establish the methods, practices or procedures for introducing evidence, but does not include authority to limit the *kind* of proof on which a party may rely. OAR 430-05-040(4)(b) limits the *kind* of evidence which may be used to prove that a request for review was mailed. The rule requires "proof from the post office" of the date of mailing and provides that "acceptable proof * * * shall be a receipt stamped by the post office showing the date mailed and the certified or registered number."

We agree with the dissent that the Board's rule does provide a uniform and reliable method of proving when a

[1] Employer also argues that OAR 438-05-040(4)(b) is not applicable, because the statute provides that a request for review is perfected by "mailing" and the rule relates only to "filing." In view of our disposition of the case, it is unnecessary to address this issue.

request was mailed and that it may well contribute to the efficiency of the system. However, the statute allows a request for review to be perfected by "mailing."[2] We conclude that the Board's rule limiting the kind of evidence sufficient to prove the fact of mailing is inconsistent with the statute and, therefore, is invalid. The Board should determine, as a jurisdictional fact, whether the evidence establishes that the request for review was mailed.

Reversed and remanded.

RICHARDSON, P. J., dissenting.

I disagree that the Board, by use of the rule requiring proof of mailing, has limited its jurisdiction to less than that provided by statute and has thereby exceeded its authority to adopt rules for the administration of its duties. I dissent.

OAR 438-05-040(4)(b) provides that, if a party files a request for review by mail, the party must provide proof of

mailing from the post office. The rule provides a means for parties to prove that a request was mailed and the date. Requiring that proof does not limit the Board's jurisdiction. It is a reasonable method of solving a thorny problem that arises if the Board is unable to locate a request for review that a party claims to have mailed. The rule provides a uniform, reliable method of establishing when the request was mailed. The additional time and expense is minimal and the burden insignificant when compared to the benefits of efficient administration of the workers' compensation system to all concerned. If a party seeking Board review can be deterred by the "onerous" burden of obtaining a "receipt stamped by the post office showing the date mailed and the certification number," perhaps the appeal has questionable merit. Employer's plight in this case represents a prime argument in favor of the rule.

[2] In instances where the legislature has chosen to define proof of mailing, it has expressly done so. *See, e.g.*, ORS 19.028; ORS 87.018.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sharon M. Dunn, Claimant.

DUNN,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-13386; CA A39337)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1986.

Brendan Stocklin-Enright, Portland, argued the cause for petitioner. With him on the brief were Terrance C. Hunt and Tamblyn & Bush, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Jeff Ellis, Certified Law Student, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded.

Richardson, P. J., dissenting.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board which dismissed her appeal for lack of jurisdiction. The referee issued an order denying the claim on August 12, 1985; the Board did not receive a request for review within 30 days. ORS 656.289(3). In February 1986, the Board received an affidavit from claimant's attorney, stating that a request had been mailed by regular mail to the Board on September 6, 1985, within the statutory time limit. We held in *Weyerhaeuser v. Miller*, 88 Or App 286, ___ P2d ___ (1987), that the adoption of OAR 438-05-040(4)(b) requiring proof from the post office that mailing of the request occurred within the time limit imposed by ORS 656.289(3) exceeds the Board's authority, and that the Board should determine, as a jurisdictional fact, whether the request was timely mailed. The same holding applies on these facts.

Reversed and remanded.

RICHARDSON, P. J., dissenting.

For the reasons stated in my dissent in *Weyerhaeuser v. Miller*, 88 Or App 286, ___ P2d ___ (1987), I would affirm the dismissal of claimant's appeal.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Catherine Wilkerson, Claimant.

WILKERSON,
Petitioner,

v.

DAVILA et al,
Respondents.

(WCB 85-01964; CA A42688)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 12, 1987.

Bruce D. Smith, Salem, argued the cause for petitioner. With him on the brief was Michael B. Dye, Salem.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed and remanded for reconsideration of extent of disability, including disability attributable to psychogenic pain.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's decision that her psychiatric condition should not be considered in determining the extent of her disability from a compensable injury. On *de novo* review, we reverse and remand.

Dr. Holland examined claimant at SAIF's request. He determined that she has psychogenic pain that is a complication or aggravation of a preexisting condition. In rating the severity of the stressors "judged to have been a significant contributor to the development or exacerbation of the current disorder," Holland assigns the level of "moderate" to "vocational injury and sequella [*sic*]." We find that the evidence establishes that the compensable injury was a material contributing cause of the present psychological symptoms. Those symptoms should be considered in determining the extent of claimant's disability. *Barrett v. D & H Drywall,* 300 Or 553, 715 P2d 90 (1986); *Grace v. SAIF,* 76 Or App 511, 709 P2d 1146 (1985).

Reversed and remanded for reconsideration of extent of disability, including disability attributable to psychogenic pain.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Larry Preston, Claimant.

PRESTON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Respondents.

(WCB 85-13376; CA A42186)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 2, 1987.

Donald M. Pinnock, Ashland, argued the cause for petitioner. With him on the brief was Davis, Ainsworth, Pinnock, Davis & Gilstrap, Ashland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Reversed; referee's order reinstated.

WARDEN, P. J.

Claimant seeks review of a Workers' Compensation Board order that reversed the referee's order and reinstated SAIF's denial of compensability. The sole issue is whether claimant's eye injury is work-related. We hold that it is and reverse.

Claimant taught social studies and coached basketball at Ashland Junior High School. Between 2:30 and 3:30 p.m. on November 20, 1984, he took two boxes of school-related papers from the school to his home. He also intended to pick up from his home statistics relating to his basketball teams to be used in practices that day. The trip to his home occurred during his "prep period,"[1] which was the sixth and last period of the school day. He had to return to the school by 4:00 p.m. for the basketball practices. He "signed out" when he left the school, as required by school policy. A former student accompanied him,[2] and she helped carry the boxes to the

[1] "Prep periods" are times during which teachers and coaches prepare for class and sports activities and for which they are paid.

[2] The former student, a 17-year old high school senior, occasionally sought claimant's counsel concerning personal and family problems. On this occasion, she had gone to claimant's school to discuss some personal problems. He told her that he did not then have time to sit and talk, because he had to drop off some papers at his home before returning to school for basketball practice. He indicated, however, that she could accompany him if she wanted and that they could talk en route to his home. She decided to do that.

porch of his home. While on the porch, he asked her to pull a particular file from one of the boxes. In doing that, she accidentally hit his left eye with her right elbow, causing damage to his eye.[3]

SAIF denied the claim on the basis that it was not work-related. The referee set aside the denial, finding that "there was a sufficient work connection between [claimant's] activity in moving the boxes and his employment." The Board reversed the referee on the theory that

> "at some point the connection with claimant's employment at the school became too attenuated to connect the injury with the employment sufficiently to be compensable. We cannot point to a single factor which is the dividing line over which

> claimant crossed because it is the combination of all of the relevant factors which led to this conclusion."

The sole question is whether claimant's injury "aros[e] out of and in the course of employment." ORS 656.005(8)(a). The ultimate inquiry under that statute is whether "the relationship between the injury and the employment [is] sufficient that the injury should be compensable * * *." *Rogers v. SAIF*, 289 Or 633, 642, 616 P2d 485 (1980). We have identified the following factors to help determine whether an injury is work-related:

> "(a) Whether the activity was for the benefit of the employer * * *;
>
> "(b) Whether the activity was contemplated by the employer and employe either at the time of hiring or later * * *;
>
> "(c) Whether the activity was an ordinary risk of, and incidental to, the employment * * *;
>
> "(d) Whether the employe was paid for the activity * * *;
>
> "(e) Whether the activity was on the employer's premises * * *;
>
> "(f) Whether the activity was directed by or acquiesced in by the employer * * *; [and]
>
> "(g) Whether the employe was on a personal mission of his own * * *." *Jordan v. Western Electric*, 1 Or App 441, 443-44, 463 P2d 598 (1970). (Citations omitted.)

All of those factors may be considered, and no one factor is dispositive. *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 575, 703 P2d 255, *rev den* 300 Or 249 (1985).

The Board found, and we agree, that claimant's activity at the time of injury was of benefit to the school. However, we disagree with the Board's findings that claimant was working on the files at his home for his own personal convenience and on his own time. Claimant could not use his classroom during his "prep period," because another teacher was holding a class there. He took the files to his home during regular school hours, a time for which he was paid. We find that claimant was not on a personal mission.

We also find that the school contemplated and, at the very least, acquiesced in claimant's activity, as demonstrated by the requirement that teachers and coaches "sign out" when

[3] Claimant was recovering from a corneal transplant performed on that eye two months earlier.

they leave the school building during school hours. That the injury occurred away from school premises weighs against the claim, but it is not decisive. *See Mellis v. McEwen, Hanna, Gisvold, supra.* We conclude that claimant's eye injury is sufficiently work-related to be compensable.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Donald D. Milburn, Claimant.

MILBURN,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 84-08598; CA A39527)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 16, 1987.

Michael T. Garone, Portland, argued the cause for petitioner. With him on the brief was Jolles, Sokol & Bernstein, P.C., Portland.

Jerry K. Brown, McMinnville, argued the cause for respondent. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order which affirmed employer's denial of compensability of claimant's hip condition. He argues that the hip condition was initially accepted by employer as compensably related to an earlier injury and that employer should not now be allowed to deny it. We affirm.

Claimant suffered a compensable injury to his left knee while working as a lumber sorter for employer in June, 1982, and he filed a claim for benefits on October 3, 1982. The claim was accepted by employer, and claimant underwent arthroscopic surgery one month later. The treating orthopedist, Dr. Bert, first noted claimant's hip pain while he was still recovering from knee surgery. The hip ailment was eventually diagnosed as "avascular necrosis," a condition in which impeded blood flow leads to bone death and, in this case, deterioration of the hip joint.

In November, 1983, Bert informed employer of his belief that the condition was related to claimant's knee injury. Claimant's wife testified that she repeatedly contacted employer and that she had received assurances from a clerk responsible for handling workers' compensation claims that the hip would be covered by the already accepted claim. The clerk was unable to substantiate or deny that account of the conversation. On February 16, 1984, claimant underwent complete surgical replacement of his hip. Although Bert requested authorization from employer, it is unclear whether employer ever responded. Employer paid for the operation and subsequent medical treatment for a period of nine months. Claimant's hip condition was subsequently reviewed by two other orthopedists. On July 31, 1984, employer issued a partial denial, disclaiming any further responsibility for the hip condition on the ground that it was not related to the compensable knee injury or to claimant's employment.

The referee and the Board rejected claimant's contention that employer is estopped to deny compensability of the hip condition under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983). In order for claimant to avail himself of the *Bauman* principle, there must be formal acceptance of the claim or condition. *Johnson v. Spectra Physics*, 303 Or 49, 733

P2d 1367 (1987). An accepted claim does not encompass conditions which were not a part of the claim at the time of the acceptance. *Price v. SAIF*, 296 Or 311, 675 P2d 479 (1984). There is no evidence that employer ever formally accepted the hip condition.

Claimant's contention that the Board erred by failing to find that the hip condition is compensable also fails on the merits. He bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability and the need for medical attention. *Hutcheson v. Weyerhaeuser*, 288 Or 51, 602 P2d 268 (1979); *Summit v. Weyerhaeuser Company*, 25 Or App 851, 857, 551 P2d 490 (1976). With regard to the hip condition, claimant's medical evidence is unconvincing. Bert merely presumes, without explanation, that the knee and hip injuries were incurred at the same time. Dr. Adams, from whom claimant sought a second opinion, relates the hip condition to alcohol abuse and "a minor injury" when claimant was struck on two occasions by some lumber. Claimant's account of that incident did not surface until nearly a year after it is alleged to have occurred. Adams characterized the lumber incident as a "minor injury." We agree with the referee that Dr. Post, an orthopedist who examined the medical reports and x-rays, gave the most complete and specific medical explanation of claimant's condition:

> "Dr. Post states to a medical probability that the hip disease was either idiopathic or caused by factors other than trauma. Dr. Post is willing to accept either accident history, i.e. stepping in a hole or being struck by 2 X 8's, and still states that:
>
> > " '...If trauma did occur, I would still not feel that it either caused or materially worsened the underlying condition as a medical probability.' "

We conclude that the hip condition is not compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carol Denny, Claimant.

DENNY,
Petitioner,

v.

HALLMARK FISHERIES et al,
Respondents.

(WCB 85-15708; CA A42685)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 4, 1987.

Benton Flaxel, North Bend, argued the cause and filed the brief for petitioner.

Paul L. Roess, Coos Bay, argued the cause for respondents. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for payment of medical benefits.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination that her left knee condition and surgery is not compensable.

Claimant had an on-the-job injury to her left knee in November, 1982. She had arthroscopic surgery in 1982 and again in 1984. In February, 1985, the parties stipulated to an award of 35 percent permanent partial disability. Claimant has had continuous left knee pain since the injury. In September, 1984, she moved temporarily to Minnesota to work as a drug and alcohol counselor trainee. She worked there for two and one-half months, but returned to Oregon, because the work involved regular stair climbing, which she found difficult. In September, 1985, she saw Dr. Bert, who had performed her second knee surgery. He diagnosed her condition as "recurrent chondromalacia" and recommended a repeat arthroscopy. Employer denied benefits for the surgery and for an aggravation claim.

The referee found, and the Board agreed, that there had been no worsening of claimant's knee condition, or, in the alternative, if the knee had worsened, that the work in Minnesota had contributed independently, thereby shifting liability to the Minnesota employer. *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1976). The referee reasoned that, although the evidence indicates that the compensable injury is a material contributing cause of the present need for surgery, *see Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981), because claimant did not file a claim

in Minnesota, under the rule stated in *Miville v. SAIF,* 76 Or App 603, 710 P2d 159 (1985), employer is relieved of liability.

Bert is the only doctor to provide an in-depth medical opinion, and that opinion is hardly straightforward. He testified that claimant's compensable condition is a "material contributing cause" of her present condition and also that the stair climbing in Minnesota "contributed independently" to the need for surgery. An examination of his reports and testimony reveals some vagueness as to the second statement, however. In a November, 1985, report to the insurer, Bert stated that he did not believe that there had been an increase in permanent disability. However, he responded "yes" to a question by claimant's lawyer in a letter of December, 1985,

whether claimant's left knee had worsened since February, 1985. He later admitted that he was not able to know whether it had worsened since February, 1985, because, before the September, 1985, exam, he had last seen claimant in August, 1984. In a deposition taken in March, 1986, he testified that claimant's condition of September, 1985, was about the same as it had been in August, 1984.

He described the process which leads to repeat knee surgery as chronic and stated that surgery is only a temporary remedy. He testified that stair climbing provides a "micro trauma" which contributes to the degenerative process, but he also indicated that the activities of everyday life cause micro traumas to a sensitive knee. He testified that he was now recommending that claimant have surgery, because "[s]he's having enough discomfort now that she's agreeable to having something done."

The parties agree that claimant has not experienced a worsening of her "underlying condition," whatever the significance of that phrase in this context. *See Hensel Phelps Const. v. Mirich,* 81 Or App 290, 724 P2d 919 (1986). The first question, however, is whether claimant's employment in Minnesota contributed to the knee condition in such a way as to shift responsibility, under Oregon law, to the Minnesota employer. The "last injury rule" in successive injury cases places full liability upon the carrier covering the risk at the time of the most recent injury *that bears a causal relation to the disability. Smith v. Ed's Pancake House, supra.*

Although Bert's testimony indicates that claimant's condition has changed, there is no evidence that she is more disabled now than she was at the time of the last award. At the time when claimant left for Minnesota, she had not been released for work, partly because of the pain in her left knee. She testified that, even at that time, any significant activity using her leg would bother her knee. We find that the Minnesota employment did not contribute independently to her disability.

Because she is no more disabled now than she was at the time of the last award, claimant has not established an aggravation claim. *See International Paper Co. v. Turner,* 84 Or App 248, 733 P2d 918, *rev allowed* 303 Or 483 (1987). The evidence does show, however, that the requested surgery is

related to the 1982 injury. It is therefore compensable under ORS 656.245.

Reversed and remanded for payment of medical benefits.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Steven M. DeMarco, Claimant.

DeMARCO,
Petitioner,

v.

JOHNSON ACOUSTICAL et al,
Respondents.

(WCB 85-01456; CA A41112)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1987.

Robert K. Udziela, Portland, argued the cause for appellant. On the brief were Diana Crane and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded with instructions to accept aggravation claim.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's denial of his aggravation claim. We reverse.

Claimant, age 23, sustained a compensable injury on July 26, 1982, while employed as a drywall installer. The work required that he lift and place heavy pieces of sheetrock, often overhead. He strained his lower back and neck when he lifted a piece of sheetrock. Due to lack of work, he stopped working as a drywall installer in September, 1982. Beginning in November, 1982, he sought treatment from several chiropractors, who believed that he would be better off in a new line of work. Although he had not graduated from high school, he had received a GED while he was in the service. He attended computer programming school at his own expense until December, 1983. He tried, unsuccessfully, to find a job as a

computer programmer. Because he needed money and could find no other work, he went back to work as a drywall installer in March, 1984.

A determination order in 1984 awarded claimant 15 percent unscheduled permanent partial disability because of the injury to his lower back. After a hearing on November 1, 1984, the referee increased the award to 25 percent unscheduled permanent partial disability. No party sought Board review.

Claimant experienced a sharp, stabbing pain in his upper back and neck at work on November 13, 1984. Dr. Crandall, his treating physician, diagnosed an acute muscular spasm and told him to remain off work. He has remained off work since that time. He filed a claim for aggravation of his 1982 injury; SAIF denied it on April 19, 1985, on the ground that his condition had not worsened.

Claimant must show that his condition has worsened after November 1, 1984, the date of the last arrangement of compensation,[1] and that the worsening was materially caused by his July, 1982, injury. A worsened condition is a changed

condition which makes a claimant more disabled, meaning less able to work, either temporarily or permanently, than at the last arrangement of compensation. *Smith v. SAIF*, 302 Or 396, 399, 730 P2d 30 (1986). Increased pain may constitute an aggravation if it reduces a claimant's earning capacity below what it was at the time of the last arrangement of compensation. *See Harwell v. Argonaut Insurance Co*, 296 Or 505, 510, 678 P2d 1202 (1984); *Consolidated Freightways v. Foushee*, 78 Or App 509, 512, 717 P2d 633, *rev den* 301 Or 338 (1986).

SAIF does not contend that claimant's condition is not the result of his July, 1982, injury. It argues, however, that there is no basis to find an aggravation, because the previous award compensated claimant for the pain that he might suffer if he went back to sheetrocking. Claimant, however, had already returned to sheetrocking in March, 1984, and had been doing that work for over seven months before the hearing. The evidence before the referee showed that claimant suffered pain while working and that, as a result, his productivity had declined. The award takes into account that claimant, who was paid at a piece-work rate, would earn less due to the pain he would suffer if he continued to install sheetrock. It does not take into account that he would find it necessary to stop sheetrocking entirely. *See Gwynn v. SAIF*, 304 Or 345, ___ P2d ___ (1987).

Claimant testified that the stabbing pain that he experienced while working on November 13, 1984, was worse and more intense than what he had suffered in the original injury or after he returned to work in March, 1984. After November 13, 1984, Crandall and Dr. Pasquesi, SAIF's evaluating physician, stated that, based on claimant's subjective complaints, his symptoms had worsened. No one contends that claimant is not a credible witness. Both doctors drew attention to increased problems in his neck. Crandall reported

[1] The Board held that November 1, 1984, the date of the hearing, is the appropriate date from which to measure claimant's worsening. SAIF does not argue that the Board erred.

that on November 13, 1984, claimant had suffered a muscle spasm in his neck. He told claimant to stop working as a sheetrocker. When Pasquesi first examined claimant on September 21, 1984, he reported that, "[i]n the cervical spine area, the patient has a full range of motion without discomfort." On April 1, 1985, however, Pasquesi stated that "flexion and rotation to the right and left causes pain in the region of the mid cervical spine area, as well as in the scapular areas." He advised claimant to avoid "constant repetitive holding of his

head in a stopped or flexed position or requiring motions from the left to right." The evidence shows that claimant's condition had worsened after November 1, 1984.

Reversed and remanded with instructions to accept the aggravation claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Claud B. Rodgers, Claimant.

RODGERS,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 84-05031; CA A40803)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 11, 1987.

Ronald L. Bohy, Salem, argued the cause for petitioner. On the brief was Rolf Olson, P.C., Salem.

Allan M. Muir, Portland, argued the cause for respondent. On the brief were John Casey Mills, Lawrance L. Paulson, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board denying temporary total disability benefits, a penalty and attorney fees. We affirm.

Claimant suffered a compensable injury in October, 1981, while working as a bucker for employer. On October 6, 1983, a hearing was held on his claim for temporary total disability benefits. The referee's order of February 29, 1984,

determined that he was medically stationary and had been released to return to regular work on August 19, 1983, and that he was "not entitled to additional temporary total disability benefits, beginning August 20, 1983, and until claim closure under ORS 656.268." Claimant did not appeal.

On October 17, 1983, Dr. Campagna, a neurosurgeon, saw claimant and shortly thereafter admitted him to a hospital for evaluation. Employer voluntarily began paying temporary total disability. Initially, Campagna prospectively released claimant for work as of January 5, 1984; however, on December 16, 1983, he indicated that claimant could not return to his former employment and recommended vocational rehabilitation. Employer stopped paying temporary total disability benefits on January 4, 1984.

Claimant sought a hearing on the termination of temporary total disability benefits, and the referee issued an order requiring employer to pay temporary total disability benefits from January 4 until claim closure, pursuant to ORS 656.268.[1] Employer moved for reconsideration. On reconsideration, the referee withdrew the original order and determined that he was bound by the earlier finding of February 29, 1984, that claimant was medically stationary. Because claimant had shown no "worsening," the referee denied his request for temporary benefits. The Board affirmed.

The referee and Board erred in concluding that the February 29, 1984, order precluded an additional award of temporary disability benefits unless claimant could prove a "worsening" of his condition. A worsening is required only when a worker seeks additional compensation *after the last award or arrangement of compensation.* ORS 656.273. It is the

standard applied when a claimant seeks benefits for an *aggravation* of a compensable condition, after the extent of disability for that condition, both temporary and permanent, has been determined. The referee's order of February 29, 1984, determined the right to temporary disability benefits on the basis of the evidence of claimant's condition *as of the date of hearing* that he was medically stationary. It did not determine claimant's right to permanent partial disability; neither did it order that the claim be closed. A claim cannot be closed unless the claimant is medically stationary. ORS 656.268. If, after the hearing and before claim closure, claimant's condition changed and he was no longer medically stationary, he could receive benefits for temporary total disability.

"Medically stationary" is defined in ORS 656.005(17) as the situation when

> "no further material improvement would reasonably be expected from medical treatment, or the passage of time."

In order to show that he was no longer medically stationary after August 20, 1983, claimant had to prove that a material improvement in his condition could be expected from medical treatment or the passage of time. He has not done so. Campagna hospitalized him for evaluation but prescribed no medical treatment. Dr. Tobias, who examined claimant at

[1] As of the hearing date, the claim had not been closed.

Campagna's request, recommended against surgery. Campagna found no objective change in claimant's condition between October, 1983, and May, 1984. There is no indication that, after the date of the October, 1983, hearing, claimant's condition changed so that either medical treatment or the passage of time would result in an improvement in his condition. He was not entitled to additional benefits for temporary disability.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jerry E. Wojick, Claimant.

WEYERHAEUSER COMPANY,
Appellant - Cross-Respondent,

v.

WOJICK,
Respondent - Cross-Appellant.

(16-86-01375; CA A40376)

Appeal from Circuit Court, Lane County.

James R. Hargreaves, Judge.

Argued and submitted May 26, 1987.

Paul J. De Muniz, Salem, argued the cause for appellant - cross-respondent. With him on the briefs was Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

James L. Edmunson, Eugene, argued the cause for respondent - cross-appellant. With him on the brief was Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed on appeal and on cross-appeal.

PER CURIAM

This case involves the amount of an attorney fees award to claimant in a workers' compensation case. The referee awarded claimant attorney fees as authorized by ORS 656.382(1) in conjunction with penalties under ORS 656.262(10) on the basis of employer's unreasonable claim processing. Employer filed a request for review of the award in the circuit court pursuant to ORS 656.388(2). Claimant filed a response and a request that the fee be increased. The court dismissed the request on the ground that only the attorney for claimant may seek review of attorney fees under ORS 656.388(2). Employer appeals, and claimant cross-appeals.

In *Greenslitt v. City of Lake Oswego*, 88 Or App 94, ___ P2d ___ (1987), we held that a circuit court has jurisdiction of

a fee dispute under ORS 656.388(2) only if the fees were awarded pursuant to ORS 656.386(1). Because the fees in this case were allowed under ORS 656.382(1), the circuit court did not have jurisdiction. *See Short v. SAIF*, 88 Or App 226, ___ P2d ___ (1987).

Affirmed on appeal and on cross-appeal.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DRYDEN,
Appellant,
v.
STATE ACCIDENT INSURANCE FUND CORPORATION et al,
Respondents.
(85-1807; CA A38520)

In Banc

Appeal from Circuit Court, Marion County.

Rodney W. Miller, Judge.

Argued and submitted March 13, 1987; resubmitted in banc September 9, 1987.

James L. Edmunson, Eugene, argued the cause for appellant. With him on the briefs was Malagon & Moore, Eugene.

Michael C. McClinton, Salem, argued the cause for respondents. With him on the brief was Clark, Marsh, Lindauer & McClinton, Salem.

WARDEN, J.

Affirmed as to dismissal of plaintiff's first claim for relief; reversed as to striking punitive damages from plaintiff's second claim for relief; and remanded.

WARDEN, J.

Plaintiff seeks damages arising from alleged acts of defendant Gordon. She claims that Gordon, as an employe of defendant State Accident Insurance Fund Corporation (SAIF), and while acting in the course and scope of his employment, negligently struck her with an automobile. Her second claim, in the alternative, alleges that Gordon intentionally struck her with the automobile.[1] The trial court granted defendants' motion to dismiss the first claim, because compliance with the notice requirements of the Oregon Tort Claims Act (OTCA), ORS 30.260 to ORS 30.300, was not alleged. The court also granted defendants' motion to strike plaintiff's claim for punitive damages, because punitive

[1] The second claim makes no allegations concerning SAIF and is against Gordon only. Plaintiff seeks punitive damages in the second claim only.

damages are not recoverable under OTCA.[2] Plaintiff appeals.

Plaintiff first argues that SAIF is not a "public body" within the meaning of OTCA and that, therefore, notice to SAIF under ORS 30.275[3] was not required. We disagree. The legislature, by enacting Or Laws 1979, ch 829, § 2 (now ORS 656.751), created SAIF "as an independent *public corporation.*" (Emphasis supplied.) "Public body" is defined for the purposes of OTCA as

> "the state and any department, agency, board or commission of the state, any city, county, school district or other political subdivision or municipal or *public corporation* and any instrumentality thereof." ORS 30.260(4). (Emphasis supplied.)

It is patent that SAIF, a public corporation created by statute, falls squarely within the definition of "public body" in

OTCA. Plaintiff, however, argues that SAIF's "unique status" as an *independent* public corporation precludes it from classification as a "public body" under OTCA. Certain distinctions may be drawn between SAIF and other governmental entities that are "public bodies" under OTCA, *see* ORS 656.753, but none of those distinctions is relevant, because SAIF is operated as a public corporation.

The Oregon Supreme Court, in holding that the statute that created SAIF does not contravene Article XI, section 2, of the Oregon Constitution, said that SAIF

> "does not have the questionable characteristics of mixed private and governmental investment or management. It has no stockholders, and its board of directors is appointed by the governor, subject to confirmation by the Senate, and serves at the governor's pleasure. ORS 656.751. It meets the test of 'public' rather than 'private' corporation stated in *Cook v. The Port of Portland,* [20 Or 580, 27 P 263 (1891))] * * *. SAIF * * * [has] exclusively governmental management and [an] absence of private investment or objective to operate for private profit * * *." *State ex rel Eckles v. Wooley,* 302 Or 37, 49, 726 P2d 918 (1986).

SAIF is also subject to government control in that its board of directors must file an annual report with the legislature and the Governor covering its activities and operations. ORS 656.751(8). It is also subject to the Public Meetings Law, *see Frohnmayer v. SAIF,* 294 Or 570, 581 n 7, 660 P2d 1061 (1983); it must request authorization from the Attorney General before employing independent counsel, *Frohnmayer v. SAIF, supra,* 294 Or at 587; and its employes are subject to the Government Ethics Law. *See Davision v. Oregon Government Ethics Comm.,* 300 Or 415, 712 P2d 87 (1985).

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[2] The judgment entered by the trial court dismissed only plaintiff's first claim for relief and struck the punitive damages claim from the second. The judgment complies with ORCP 67B.

[3] ORS 30.275 provides, in pertinent part:

"(1) No action arising from any act or omission of a public body or an officer, employe or agent of a public body within the scope of [OTCA] shall be maintained unless notice of claim is given as required by this section.

"(2) Notice of claim shall be given * * *."

"* * * * *

"(b) For [claims other than wrongful death], within 180 days after the alleged loss or injury."

We agree with the Attorney General, who, when confronted with precisely the same issue stated:

> "Regardless of what other distinctions, if any, may be drawn between [SAIF] and other state agencies, [SAIF] is clearly *at least* a 'public corporation' under [ORS 30.260(4)] and thus a public body within the meaning of [OTCA]. It is not merely organized under but created by law, and its organization and functions are not merely authorized but prescribed by law.
>
> "SAIF may or may not be a 'state agency' for purposes of

> other statutes, but it is subject to the obligations and protections of [OTCA]." 40 Op Atty Gen 344 (1980). (Emphasis in original.)

The trial court did not err in dismissing plaintiff's first claim, because compliance with the notice requirements of ORS 30.275 was not alleged. *See Urban Renewal Agency v. Lackey*, 275 Or 35, 40, 549 P2d 657 (1976); *Georgeson v. State of Oregon*, 75 Or App 213, 706 P2d 570, *rev den* 300 Or 332 (1985).[4]

Plaintiff next contends that the trial court erred in granting defendants' motion to strike her claim for punitive damages. We agree. As noted, *see* n 1, *supra*, plaintiff seeks punitive damages in her second claim for relief only. That claim is against Gordon personally and makes no allegations concerning SAIF. Because the claim alleges an intentional tort, outside OTCA,[5] the trial court erred in striking the punitive damages claim.

Affirmed as to dismissal of plaintiff's first claim for relief; reversed as to striking punitive damages from plaintiff's second claim for relief; and remanded.

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[4] We also find it significant that the legislature did not exempt SAIF from OTCA, as it did from other statutes. ORS 656.753.

[5] ORS 30.270(2) provides that no punitive damages shall be awarded on a claim brought under OTCA against a public body or its officers, employes and agents.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Wesley L. Simpson, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Petitioners,
v.
SIMPSON,
Respondent.
(WCB 85-05267; CA A40209)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1987.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioners. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief was Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Employer challenges the award of permanent total disability, arguing that, because claimant has residual physical capacity, it was error for the referee and Board to excuse him from the requirement that he seek work. We affirm.

Claimant, 54 years old, has worked primarily as a mechanic and welder since 1954. He has not been employed since he suffered a compensable injury to his back in 1979. The referee made these pertinent findings concerning his condition:

> "At present claimant experiences constant back pain and pain in both legs, worse on the right. He also experiences burning in the left groin and occasional numbness in both legs. Claimant has difficulty sitting, although if he squirms he is able to sit for twenty to thirty minutes. Claimant can stand in one position for less than one half hour.
>
> "* * * * *
>
> "The medical evidence establishes that claimant is severely disabled by his industrial injury. At most claimant is capable of doing light work. In addition, claimant has a strong psychological component to his pain. I find that his psychological component is not voluntary and claimant is not malingering. Consequently, I consider all claimant's subjective

complaints in rating the extent of his disability. *See, Barrett v. Coast Range Plywood,* 294 Or 641[, 661 P2d 926] (1983).

"In addition to his physical and psychological problems, claimant is limited by social and vocational factors. He is 54 years old and has only a seventh grade education. His work has generally been in jobs requiring heavy labor. The sole vocational expert concludes that claimant has few transferable skills and that without further training he is incapable of engaging in regular gainful employment."

Employer argues that a person who seeks odd-lot permanent total disability should never be excused from the requirement of ORS 656.206(3) to prove that reasonable efforts have been made to obtain employment:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made *reasonable* efforts to obtain such employment." (Emphasis supplied.)

However, just as physical incapacity may make a worker's efforts to seek work futile, and therefore reasonable, non-medical factors which establish permanent total disability under the odd-lot doctrine also may make efforts to seek work futile. *Welch v. Banister Pipeline,* 70 Or App 699, 690 P2d 1080 (1984), *rev den* 298 Or 470 (1985). In this case, claimant's efforts to seek work were minimal. However, his physical incapacity, considered together with his non-medical disabilities, support the conclusion that greater effort would have been futile. *Madaras v. SAIF,* 76 Or App 207, 707 P2d 1302 (1985).

Affirmed.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Nibby J. Seabeck, Deceased, Claimant.

COTTRELL,
Petitioner on Review,

v.

EBI COMPANIES et al,
Respondents on Review.

(WCB 84-12966; CA A38940; SC S33933)

In Banc

On Review from the Court of Appeals.*

Argued and submitted September 2, 1987.

Michael M. Bruce, Eugene, argued the cause and filed the petition on behalf of the petitioner on review.

Jerald P. Keene, Portland, argued the cause on behalf of the respondents on review. With him on the response was Roberts, Reinisch & Klor, P.C., Portland.

GILLETTE, J.

The order of the Workers' Compensation Board and the decision of the Court of Appeals are affirmed.

* On an appeal from an Order of the Workers' Compensation Board. 84 Or App 472, 734 P2d 383 (1987).

GILLETTE, J.

The issue in this workers' compensation case is whether claimant is entitled to survivor's benefits under ORS 656.226, which provides:

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under ORS 656.001 to 656.794 the same as if the man and woman had been legally married."

Claimant and the deceased worker, Seabeck, lived together as husband and wife for approximately three years. During that time, they had a child together. Approximately one month before Seabeck's death, he moved out of the home and into a separate apartment because he and claimant were having difficulties with their relationship.

After Seabeck's death, claimant filed for survivor's benefits under the cohabitation statute.[1] The insurer denied the claim. A Workers' Compensation Department referee approved the denial on the ground that ORS 656.226 requires that the claimant be cohabiting with the subject worker at the time of the accident. The referee found that claimant and Seabeck were not cohabiting at that time. The Workers' Com-

pensation Board affirmed the referee's decision, as did a majority of the Court of Appeals panel below. *Cottrell v. EBI*

Companies, 84 Or App 472, 734 P2d 383 (1987). The claimant then brought this petition for review. We affirm.

Claimant first argues that ORS 656.226 does not expressly require that the period of cohabitation include the time of the accident — in this case, the date Seabeck was killed. Under claimant's proposed interpretation of the statute, any and all persons who had ever cohabited for more than one year with a worker and who, as a result, produced children still living at the time of the worker's accident, would qualify as surviving cohabitants eligible for benefits under ORS 656.226.

Claimant's proposed interpretation, although somewhat strained, is a permissible reading of the statute. It is not, however, the only permissible reading. The Court of Appeals previously has interpreted the statute as requiring that the period of cohabitation include the time of the accident. *Amos v. SAIF,* 72 Or App 145, 152, 694 P2d 998 (1985). The statutory language lends itself to either interpretation.

The ambiguity cannot be resolved through resort to the legislative history. No legislative history survives from the statute's original enactment in 1927.[2] The statute was amended in 1983 to afford survivor's benefits to males who had cohabited with deceased female workers. Or Laws 1983, ch 816, § 4. *See Hewitt v. SAIF,* 294 Or 33, 653 P2d 970 (1982). That amendment, however, did not deal with the cohabitation requirement. We are, therefore, left to determine which interpretation is more consistent with the legislature's intent without guidance from any legislative history.

Claimant urges that she meets the only two express requirements of the statute — she cohabited with Seabeck for over a year and she bore his child. A married woman who had done the same would, she points out, be entitled to benefits even if separated from her husband at the time of his death.

---

[1] A "surviving cohabitant" under ORS 656.226 is entitled to benefits under ORS 656.204, which provides, in part:

> "If death results from the accidental injury, payments shall be made as follows:
>
> "* * * * *
>
> "(2) If the worker is survived by a spouse with children of the deceased, monthly benefits shall be paid in an amount equal to 4.35 times 50 percent of the average weekly wage to the surviving spouse until remarriage. If the worker is survived by a spouse with no children of the deceased, monthly benefits shall be paid in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs. The surviving spouse also shall be paid $150 per month for each child of the deceased until such child becomes 18 years of age * * *."

Even if the claimant does not qualify for benefits under ORS 656.226, the decedent's child would qualify for benefits under ORS 656.204(4).

[2] As originally enacted, the statute read:

> "In case an unmarried man and an unmarried woman shall have cohabited in the state of Oregon as husband and wife for over one year prior to the date of an accidental injury received by such man, and children shall be living as a result of said relation, said woman and said children shall be entitled to compensation under this act the same as if said man and woman had been legally married."

Or Laws 1927, ch 414, § 1.

Treating her differently, claimant says, defeats the statutory directive that she be allowed compensation "the same as if [she and Seabeck] had been legally married."

This argument misses the point. Whether claimant *was* in a position the same as that of a legally married but separated spouse is what this case is all about. We look to the statutory scheme as a whole to determine what that "same" position would be. The answer does not help claimant.

Under the Workers' Compensation Law, a surviving spouse is eligible for benefits only if the surviving spouse's marriage to the worker was in effect at the time of the worker's death. Benefits are not available to a former spouse. ORS 656.204(3).[3] Following the directive of ORS 656.226 therefore requires that benefits not be awarded if the cohabitation relationship has ended, *i.e.*, the parties have gone through what was, for their relationship, the functional equivalent of a dissolution of marriage. The parties may separate temporarily without losing eligibility under ORS 656.226, but a permanent separation ends not only the relationship but also eligibility under the statute. We hold that, in order to qualify for survivor's benefits under ORS 656.226, the cohabitation relationship must exist at the time of the worker's death.

Second, claimant argues that, assuming continuing cohabitation is required, she was cohabiting with Seabeck at the time of his death. The Court of Appeals has stated that "[t]he nature of the relationship and not the number of days spent in the same location determines whether cohabitation exists" for the purpose of ORS 656.226. *Bowlin v. SAIF*, 81 Or App 527, 532, 726 P2d 1186 (1986). There, the court noted that the claimant and the decedent "were not always together every day and every night, but there is *no* evidence that they ever intended to terminate their long term relationship." *Id.* (emphasis in original).

This court has construed the term, "cohabitation," in a context analogous to the one presented in this case. In

Wadsworth v. Brigham, 125 Or 428, 259 P 299, 266 P 875 (1928), this court construed the following statute, which contained language almost identical to that of the cohabitation statute at issue here:

> "In case a man and a woman, not otherwise married heretofore, shall have cohabited in the state of Oregon as husband and wife, for over one year, and children shall be living as a result of said relation, said cohabitation, if children are living, is hereby declared to constitute a valid marriage and the children born after the beginning of said cohabitation are hereby declared to be the legitimate offspring of said marriage."

Or Laws 1925, ch 269, § 1. We stated in *Wadsworth:*

> "[I]t is said that during this period of cohabitation John R. Brigham had rooms elsewhere. That would not prevent his cohabitation with the plaintiff's mother, as cohabitation does

[3] ORS 656.204(3) states:

> "If a worker leaves a child under the age of 18 years by a divorced husband or wife, and the child is in the custody of the divorced husband or wife, $150 per month shall be paid for each such child until the child becomes 18 years of age. * * *"

> not mean that the parties must live together in the same room continually or occupy one room, as the essence of cohabitation is the living together and the sexual relations, and there may be some degree of living apart and an occasional trip away without destroying the relation, so that it was not a part of the plaintiff's case to prove that the three of them were huddled in one room all the time and never departed therefrom."

125 Or at 482.

The Court of Appeals' definition of "cohabitation" is consistent with the statement quoted above, and we approve it. The question remaining, therefore, is whether claimant and Seabeck intended their change to separate living quarters to mark the termination of their relationship or merely to provide a brief respite during which they could work out their problems. The Court of Appeals decided that question adversely to claimant, and we will not disturb that factual determination on review. *Weller v. Union Carbide*, 288 Or 27, 29, 602 P2d 259 (1979).

The order of the Workers' Compensation Board and the decision of the Court of Appeals are affirmed.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of William R. Gwynn, Claimant.

GWYNN,
Petitioner on Review,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION et al,
Respondents on Review.

(WCB 84-11354; CA A38534; SC S33828)

On Review from the Court of Appeals.*

Argued and submitted July 7, 1987.

Ronald L. Bohy, Salem, argued the cause and filed the petition for petitioner on review.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents on review.

Before Peterson, Chief Justice, and Lent, Campbell, Carson, Jones and Gillette, Justices.

LENT, J.

Remanded to the Court of Appeals for reconsideration in light of this opinion.

* Judicial Review of Order of Workers' Compensation Board. 84 Or App 67, 733 P2d 895 (1987).

LENT, J.

The issue is whether an award of compensation for permanent partial disability that is based in part on a predic-

tion that from time to time "future symptomatic flareups" will occur precludes an award of compensation under ORS 656.273(1) for such flareups even if they produce greater disability than that for which the original award was made.[1] We hold that it does not.

Claimant, who had received a workers' compensation award for unscheduled permanent partial disability, filed a claim under ORS 656.273 with respondent State Accident Insurance Fund (SAIF).[2] SAIF denied the claim. On judicial review on the record forwarded by the Workers' Compensation Board (Board), the Court of Appeals affirmed the denial, finding that "[c]laimant's symptoms resulting in time loss were anticipated at the time of the last arrangement of compensation." *Gwynn v. SAIF,* 84 Or App 67, 69, 733 P2d 895 (1987).

We take as facts those that are undisputed or found by the Court of Appeals. *Sahnow v. Fireman's Fund Ins. Co.,* 260 Or 564, 568-69, 491 P2d 997 (1971). Claimant injured his back in 1981 while working as a mechanic for respondent Siletz Trucking Company. Chronic pain from the injury eventually forced him to quit his job, which required him to lift and to manipulate heavy equipment. His physician recommended that he accept only "light duty" work, *i.e.,* work not involving lifting more than 40 pounds or otherwise placing a significant strain on his back.

His claim was first closed in March 1982 without any award of compensation for permanent disability. Some time later claimant filed a claim for additional compensation for

worsened conditions resulting from his 1981 injury. ORS 656.273(1). SAIF, Siletz Trucking Company's insurer, denied this claim in June 1983 but later settled the claim. The settlement agreement stated in relevant part:

> "IT IS HEREBY STIPULATED AND AGREED between the parties that all issues raised or raisable at this time may be fully compromised and settled by SAIF Corporation paying to the claimant and the claimant accepting an award of 64 degrees for 20 percent unscheduled permanent partial disability for injury to his dorso lumbar spine, * * * that in consideration of the increased compensation, claimant acknowledges full compensation for the above-described injury to his dorso lumbar spine and all related complaints thereto, and further agrees that the pending Request for Hearing may be dismissed with prejudice."

The settlement was approved by a Board referee on December 21, 1983. ORS 656.289(4).

In November 1983, claimant accepted from another employer a job that he believed would involve supervisory work without heavy lifting. The job proved to require frequent

[1] 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."

[2] The permanent partial disabilities listed in ORS 656.214(2) to (4) are commonly called "scheduled" disabilities. All other permanent partial disabilities are called "unscheduled" disabilities and are rated by the permanent loss of earning capacity due to a 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, training, skills and work experience." ORS 656.214(5).

lifting well beyond the 40-pound limit imposed by his physician. After pain again forced him to quit work in July 1984, he sought compensation for temporary total disability by filing with SAIF a second ORS 656.273(1) "claim for aggravation" of his original back injury.

A claim for aggravation must be based on "worsened conditions" since the last award or arrangement of compensation. ORS 656.273(1). SAIF denied this aggravation claim because it concluded that claimant had not shown that his condition was "objectively worse" than at the time of his permanent partial disability award. Following a hearing on the claim in May 1985, the referee affirmed the denial and on review the Board affirmed the referee's order. The Board stated:

> "The evidence persuades us that following the last arrangement of compensation, claimant experienced a mere exacerbation of symptoms without a worsening of his underlying condition. While a symptomatic worsening alone can represent a compensable claim under the proper facts, * * * it is generally not sufficient if the claimant has received an award of permanent partial disability that takes into account future symptomatic flare-ups. * * * In the present case, claimant has

> received an award of 64 degrees for 20 percent unscheduled permanent partial disability for the low back. We find that this award contemplated future symptomatic exacerbations."

The Board did not identify the evidence on which it found that the award "contemplated future symptomatic exacerbations."

On judicial review, the Court of Appeals affirmed the Board's decision: "On *de novo* review, we find that claimant has not suffered a worsening of his condition that would qualify as an aggravation under ORS 656.273. Claimant's symptoms resulting in time loss were anticipated at the time of the last arrangement of compensation." *Gwynn,* 84 Or App at 69. The court, in contrast to the Board, did not find that the *award* contemplated claimant's symptoms; rather, the court found that the symptoms were anticipated *at the time of* the award. From a later statement in its opinion, we infer that the court would find that symptoms were "anticipated" at the time of the award whenever it was then "knowable that the claimant will experience a waxing and waning of symptoms or that certain activities will activate symptoms." 84 Or App at 71. We further infer from this statement that the Court of Appeals found no worsening of claimant's condition because it concluded that the pain that forced him to leave work was caused by exceeding the work limits recommended by his physician at the time of his permanent partial disability award.

It is not this court's function to determine the facts in workers' compensation cases; on judicial review, that function belongs to the Court of Appeals. *Sahnow v. Fireman's Fund Ins. Co., supra.* Whether a claimant's condition has "worsened" is a question of fact, and we express no opinion on that issue in this case. Our intention is only to clarify the legal premises on which that factual determination must be made.

The Board found that claimant's condition was not worse because his permanent partial disability award "con-

templated" his "future symptomatic exacerbations."[3] Whether a claimant's condition has worsened is a question,

the answer to which cannot turn on factors which have nothing to do with the condition of claimant's body.

The Court of Appeals' finding that at the time of the award it was "knowable" that claimant would experience a "waxing and waning" of symptoms tells us nothing more than that. It does not tell us that this quality of being knowable was taken into consideration in reaching the agreement that produced an award of 64 degrees for unscheduled permanent partial disability. If it did, it would be subject to the same criticism as is the Board's finding, *i.e.*, on what evidence would it rest?

We shall assume, *arguendo,* that there was evidence to support a finding that the amount of the award of compensation for unscheduled permanent partial disability was predicated in part at least on the fact that from time to time in the future claimant's physical condition or symptoms would become exacerbated to the extent of temporarily diminishing his earning capacity. That being so, how great a diminishment and of what duration will support an award of additional compensation under ORS 656.273?

We commence with the reminder that there are four types of disability for which compensation is awarded. They are: (1) temporary partial disability, ORS 656.212; (2) temporary total disability, ORS 656.210; (3) permanent partial disability, ORS 656.214; and (4) permanent total disability, ORS 656.206. Any disability can only be classified at any one time under one of those headings because each is exclusive of any other. Of these we shall not discuss temporary partial disability because it is not involved in this case.

Permanent total disability "means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation," which is one that "the worker has the ability and the training or experience to perform, or [one] which the worker is able to perform after rehabilitation." ORS 656.206(1)(a).

Temporary total disability is not defined by statute. In *Cutright v. Weyerhaeuser Co.,* 299 Or 290, 295, 702 P2d 403

(1985), we stated that the adjectives "permanent" and "temporary" describe duration, not the extent, of disability. "Partial" and "total" describe extent. It follows that if a worker meets the test of being totally disabled but that it cannot be said that the disability is permanent, that worker is temporarily totally disabled.

[3] We cannot tell from the record what evidence led to that statement. Claimant's permanent partial disability award was based entirely on an agreement with SAIF. The agreement does not state that the award was intended to compensate "future symptomatic exacerbations," and we find no extrinsic evidence in the record from which this intention can be inferred.

If a worker is permanently disabled but not to the extent of being totally disabled, as the statute defines total disability, that worker must be permanently partially disabled. The fact that the worker is not totally disabled excludes the worker from the class of those permanently totally disabled, and either the fact that the disability is permanent or that it is not total excludes the worker from the class of those temporarily totally disabled.

To be a bit redundant but to emphasize a point, one who is only temporarily disabled cannot fall into either class of permanent disability.

When a worker sustains an accidental injury arising out of and in the course of employment that requires either medical services or results in disability, the worker has sustained a compensable injury for workers' compensation purposes. ORS 656.005(8). Putting aside nondisabling compensable injuries and injuries only temporarily partially disabling, this court ordinarily sees cases in which a worker has been temporarily totally disabled for at least a short time. Compensation is payable for the worker's temporary total disability according to the terms of ORS 656.210(3).[4]

Let us assume that a claim for payment of compensation has been made for temporary total disability. When no further material improvement may reasonably be expected from medical treatment, the worker is medically stationary. ORS 656.005(17). If at that point the worker is not enrolled and actively engaged in training, the extent of permanent disability, if any, may be fixed in any one of the several ways

described in the Workers' Compensation Law. In this case no award for permanent disability was made on original closure, but when claimant filed a claim under ORS 656.273, he and the insurer agreed by way of settlement that he had an unscheduled permanent partial disability equal to 64 degrees, and the referee approved that settlement. Both the worker and the insurer were bound by that agreement. As noted above, we shall assume, *arguendo,* that both parties agreed that a part of the award was based on the fact that following the time of settlement, from time to time claimant's physical condition or symptoms would become exacerbated or even lessened, *i.e.,* that there would be some "waxing and waning."

Compensation is not payable under the Workers' Compensation Law for symptoms alone, but to the extent that symptoms, such as pain, dizziness, nervousness, etc., cause loss of function of the body or its parts and, in the case of unscheduled disability, resulting loss of earning capacity, the disabling effects of the symptoms are to be considered in fixing awards for disability. *See Harwell v. Argonaut Insurance Co.,* 296 Or 505, 509-11, 678 P2d 1202 (1984); *Weller v. Union Carbide,* 288 Or 27, 34-35, 602 P2d 259 (1979). The mere "waxing" of a physical condition or of a symptom, whether or

[4] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period."

not anticipated, will not amount to a worsening sufficient to satisfy the requisites for a claim under ORS 656.273. But what if the waxing results in a greater disability?

If waxing continues to the point where the worker is incapacitated from regularly performing work at a gainful and suitable occupation, by definition the worker is totally disabled. It is logically inescapable that this is a worsening. If the worker is totally disabled, the worker becomes entitled to compensation for either temporary or permanent total disability.

If waxing continues to the point where the worker's condition falls short of total disability, as statutorily defined, but becomes medically stationary at an extent greater than previously awarded, this too must be a worsening, for the worker's loss of capacity to earn has been increased.

Again, if we assume that the award of 64 degrees was predicated on anticipation that there would be some short periods of time in which claimant's physical condition would worsen or symptoms would flare up, or wax, and then subside, it would not be fair to the insurer, nor do we perceive that the

law requires, that payment of additional compensation for such short periods should be ordered. On the other hand, if claimant's physical condition worsens or the symptoms of his injury produce a greater disability for more than the short time anticipated, the law does require additional compensation.

The question is how to draw the line between the period of incapacity that will justify payment of compensation and that which constitutes a mere flareup that has been taken into consideration by the fixing of the existing award. We conclude that ORS 656.210(3) provides a model. If the worker, as a result of worsening of the worker's condition from the original injury, becomes totally disabled for more than 14 consecutive days or becomes an inpatient at a hospital for treatment of that condition, the worker is at least entitled to compensation for temporary total disability. If inpatient treatment is required or a flareup exceeds such 14-day period, when the worker's medical condition becomes stationary, the worker's degree of permanent disability must be fixed in one of the ways prescribed by the Workers' Compensation Law, and if that disability exceeds 64 degrees or is total, the appropriate award must be made.

This case is remanded to the Court of Appeals to determine on the evidence whether "waxing and waning" was anticipated and figured in arriving at 64 degrees of disability in this case. If not, that factor is not to be taken into account in deciding this case. If it was anticipated, the court is to decide whether claimant is entitled to any additional compensation under the guidelines herein stated.

Remanded for further consideration.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Harold Turner, Claimant.
INTERNATIONAL PAPER COMPANY,
Respondent on Review,
v.
TURNER,
Petitioner on Review,
BOHEMIA, INC. et al,
Respondents.

(WCB 83-09731, 84-02465; CA A39913; SC S33861)

On review from the Court of Appeals.*

Argued and submitted July 7, 1987.

Mike Stebbins, North Bend, argued the cause for petitioner on review. With him on the petition was Hayner, Stebbins & Coffey, North Bend.

Paul L. Roess, Coos Bay, argued the cause for respondent on review.

Before Peterson, Chief Justice, and Lent, Campbell, Carson, Jones and Gillette, Justices.

LENT, J.

Remanded to the Court of Appeals for reconsideration in light of this opinion and the opinion in *Gwynn v. SAIF*, 304 Or 345, ___ P2d ___ (1987).

* Judicial Review of Order of Workers' Compensation Board. 84 Or App 248, 733 P2d 918 (1987).

LENT, J.

The issue is whether a claim for additional compensation under ORS 656.273(1) must necessarily fail because conditions that are relied on for that claim were anticipated when claimant received his last award.[1] We hold that such anticipation does not necessarily bar the claim.

We take the facts from those that are undisputed and from those found by the Court of Appeals on its judicial review on the record made before the Workers' Compensation Board (Board). *Sahnow v. Fireman's Fund Ins. Co.*, 260 Or 564, 568-69, 491 P2d 997 (1971).

In 1978 claimant sustained an injury to his left knee while employed at International Paper Company (IPC).[2] On January 15, 1980, this claim was closed with an award of

[1] ORS 656.273(1) states:

"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."

[2] While employed by IPC, claimant had injured his left leg in 1977, for which he had received an award of compensation for permanent partial disability equal to five percent loss of use or function of the left leg, which is seven and one-half degrees under the schedule found in ORS 656.214(2)(c).

compensation for temporary total disability from the date of injury to about four weeks thereafter. There was no award of compensation for permanent disability.

About four months later, the claim was reopened for performance of a high tibial valgus osteotomy. On February 4, 1982, the claim was again closed by a determination order that reflects that claimant received compensation for temporary total disability from May 23, 1980, through March 1, 1981, and he was awarded compensation for permanent partial disability "equal to 15 degrees for 10 percent loss of your left leg (knee)." As of that date he had 22.5 degrees (15 percent loss of use or function of the leg) of permanent partial disability in the leg. That award was affirmed by a referee of the Board following a hearing on March 30, 1983, which has been treated as the last award or arrangement of compensation for the purpose of ORS 656.273(1).

In July 1983, claimant was hired by Bohemia, Inc., where his work involved significant standing and other use of

his left leg. After two weeks of that employment, he quit because of pain, swelling and cramps in the leg. He filed a claim under ORS 656.273(1) against IPC for additional compensation for worsened condition and "double shot" by filing a claim against Bohemia for a new injury. Both State Accident Insurance Fund Corporation (SAIF), as insurer for Bohemia, and IPC denied the respective claims.

Claimant requested hearing on the denials, and the referee found that there had been no new injury but that there had been a worsening of the condition resulting from the 1978 injury at IPC; therefore, the referee affirmed SAIF's denial and ordered the claim against IPC reopened. The Board affirmed on review, and IPC sought judicial review in the Court of Appeals.

The Court of Appeals, on *de novo* review, found that claimant had not suffered a new injury at Bohemia and that "claimant has not suffered an aggravation" and reversed the Board. *International Paper Co. v. Turner,* 84 Or App 248, 733 P2d 918 (1987). The court wrote:

> "In order to establish an aggravation of his scheduled leg disability so as to warrant a reopening of the claim against International Paper, claimant must prove that his condition is worse. ORS 656.273. A worsened condition means a *change* which makes a claimant more disabled, either temporarily or permanently, than he was at the time of the last award of compensation. *See Smith v. SAIF,* 302 Or 396, 730 P2d 30 (1986).[1] On *de novo* review, we find that there has been no change in claimant's condition and that he has experienced only a recurrence of symptoms which were anticipated at the time of the last arrangement of compensation.
>
> "In June, 1982, following the removal of a step staple, Dr. Holbert reported that 'when [claimant] is active on the knee, it swells up.' At the hearing of March 30, 1983, which was held before the last award of compensation, claimant testified that, if he were to return to a job which required him to be on his feet for eight hours, he would experience swelling and pain in his knee. When claimant went to work for Bohemia, that is what he experienced. In Dr. Hayhurst's opinion, claimant's work at Bohemia did not result in a 'significant change in his symptomatology [sic],' or, in fact, in any 'significant symp-

tomatology [sic].' The conditions that occurred at Bohemia were anticipated when claimant received his last award. We conclude that claimant has not shown that his condition has

changed since the last arrangement of compensation and, therefore, we reverse the Board's decision awarding benefits for an aggravation." (Emphasis in original.)

"[1] Because compensation for a scheduled disability is for loss of use of a scheduled body part, ORS 656.214, 'more disabled' in this case means increased loss of use of that body part."

84 Or App at 250-51.

As in *Gwynn v. SAIF*, 304 Or 345, ___ P2d ___ (1987), we are bound by the facts as found by the Court of Appeals, but we question the legal premises under which the evidence was evaluated. As we did in *Gwynn*, we note that the Court of Appeals did not make any finding of fact that the award of 22.5 degrees was predicated on anticipated recurrence of symptoms. The court only found that a recurrence of symptoms was *anticipated at the time* of the last arrangement of compensation. Under our decision in *Gwynn* it is necessary that this case be remanded to the Court of Appeals to determine whether, and on what evidence, the award of 22.5 degrees was in any part predicated on the anticipated recurrence of symptoms.

Whatever the resolution of that issue of fact may be, the Court of Appeals must then apply the analysis we have described in *Gwynn* to determine whether claimant is entitled to additional compensation for worsened conditions resulting from the 1978 injury.

This case is remanded to the Court of Appeals for reconsideration in light of this opinion and the opinion in *Gwynn v. SAIF, supra.*

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Johnnie Stepp, Claimant.

STEPP,
Petitioner on Reconsideration,

v.

SAIF CORPORATION et al,
Respondents on reconsideration.

(WCB 83-01242; CA A34646; SC S32946)

On petitioner's petition for reconsideration of the decision of the Supreme Court.*

Argued and submitted April 8, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner on reconsideration. With him on the petition were Karen M. Werner and Malagon & Moore, Eugene.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondent on reconsideration.

Before Peterson, Chief Justice, and Lent, Linde, Campbell, Carson and Jones, Justices.

PETERSON, C. J.

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

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* Judicial review of order of Workers' Compensation Board. 78 Or App 438, 717 P2d 216, *remanded* 302 Or 148, 727 P2d 125 (1986), *aff'd on reconsideration* 302 Or 459, 729 P2d 577 (1987).

PETERSON, C. J.

The claimant seeks review of the Court of Appeals' affirmance of a Workers' Compensation Board order that reversed a referee's award of permanent total disability. *Stepp v. SAIF,* 78 Or App 438, 717 P2d 216 (1986). On October 28, 1986, this court remanded the case to the Court of Appeals for consideration in light of our decision in *Smith v. SAIF,* 302 Or 109, 727 P2d 123 (1986) *("Smith I"). Stepp v. SAIF,* 302 Or 148, 727 P2d 125 (1986) (memorandum opinion). We thereafter reconsidered our opinion in *Smith I,* withdrew the earlier opinion and issued a superseding opinion. *Smith v. SAIF,* 302 Or 396, 730 P2d 30 (1986) *("Smith II").* SAIF then petitioned for reconsideration in the present case. We allowed the petition and affirmed the decision of the Court of Appeals. *Stepp v. SAIF,* 302 Or 459, 729 P2d 577 (1986) (memorandum opinion). The claimant then petitioned for reconsideration, which was allowed. We again affirm the decision of the Court of Appeals.

There is little real dispute about the facts. On January 31, 1977, the claimant suffered multiple compensable injuries while employed by Perry Brothers Veneer Company,

insured by the State Accident Insurance Fund Corporation (SAIF). The claimant then was 51 years old. He suffered post-concussion syndrome with extreme nervousness, chronic cervical strain, chronic lumbar strain and chronic post-concussive muscle tension headaches.

The claim was closed by a determination order on October 26, 1978, that awarded compensation of 15 percent unscheduled permanent partial disability (PPD) for injuries to the head, neck and back. The claimant appealed the determination order. By a stipulated order of April 11, 1979, the claimant's award was increased to a total of 80 percent (256 degrees) unscheduled PPD.

In May 1980 the claimant saw his doctor complaining of headaches and increased cervical and lumbar pain following work at home on a chicken coop. He thereafter asserted an aggravation claim. SAIF denied the claim.

On April 30, 1982, a referee set aside the denial, ordered the claim reopened as of May 16, 1980, and remanded

the aggravation claim to SAIF for acceptance as a compensable claim. The Evaluation Division thereafter closed the claim with a determination order that granted the claimant additional temporary total disability (TTD) benefits but denied his claim for additional unscheduled PPD.

The claimant requested a hearing. On September 13, 1983, the referee ordered an award of compensation for permanent total disability.

The Board reversed the referee's award of permanent total disability. It found:

> "* * * [W]e find that claimant's physical and mental conditions are no different now than they were at the time of the execution of the 1979 stipulation awarding claimant 80% permanent partial disability and we, therefore, disagree with the Referee's award of permanent total disability.
>
> "Although it is true that claimant suffered an aggravation of his condition in May 1980, the medical evidence clearly indicates that this was only a temporary exacerbation and that claimant has since returned to his pre-aggravation status with no additional impairment."

The Court of Appeals reviewed the record *de novo* and found:

> "After reviewing the record *de novo,* we agree with the Board that claimant failed to prove a permanent worsening of his compensable condition since the stipulated order. Although there is substantial evidence that claimant suffered an aggravation in May, 1980, we are satisfied that that worsening was temporary and that claimant thereafter returned to his preaggravation status, without any additional permanent impairment."

78 Or App at 441. This court accepts and will not disturb this finding. *Boise Cascade v. Starbuck,* 296 Or 238, 240, 245, 675 P2d 1044 (1984); *Sahnow v. Fireman's Fund,* 260 Or 564, 568, 491 P2d 997 (1971).

The Court of Appeals also stated:

> "Claimant appears to argue, however, that, once he proves

a temporary worsening, he is entitled to a redetermination of the extent of his permanent disability, even though his compensable condition has not permanently worsened. He cites no authority for that proposition, and we have found none.[1] The effect of that argument would allow him to relitigate the

April, 1979, stipulated order for permanent partial disability. This is not permissible. The stipulated order is conclusive as to the extent of the disability on that date. *Waldroup v. J. C. Penney Co.*, 30 Or App 443, 448, 567 P2d 576 (1977). That determination cannot be relitigated in an aggravation claim. *Deaton v. SAIF*, 33 Or App 261, 263, 576 P2d 35 (1978). Without a permanent worsening of the compensable condition, there is no justification for redetermining the extent of permanent disability.[2]

"[1] * * *

"[2] Claimant can also be understood to argue that he was, in fact, permanently and totally disabled when he stipulated to the permanent partial disability award. Without evidence of a permanent worsening since that time, he is bound by the stipulation."

78 Or App at 441-42.

The findings of the Board and Court of Appeals are that the injury-caused condition is no worse than in 1979. The claimant argues that, even with no change in that condition, he is entitled to increased disability compensation. He asserts:

"The Court of Appeals ignored the fact that passage of time itself is a factor which could not have been taken into account in a prior proceeding, including the history of exacerbation and subjective complaints of worsening. A claimant who seeks a contemporary evaluation of lost earning capacity upon closure of an aggravation claim is not, as the Court of Appeals in this case suggested, seeking to 'relitigate' an earlier claim closure, 78 Or App at 442. There is a new body of operative facts reflecting present inability to work, upon which the redetermination is based."

To respond to claimant's argument we examine several workers' compensation statutes. ORS 656.206(1) defines PTD as:

"* * * the loss, including pre-existing disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

ORS 656.214(5) concerns PPD awards of unscheduled disability and provides:

"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, training, skills and work experience. * * *"

ORS 656.273(1) provides for additional benefits for worsened conditions resulting from the original injury. It states:

> "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."

ORS 656.273(2) states that "[t]o obtain additional services or disability compensation, the injured worker must file a claim for aggravation. * * *"

ORS 656.273(1) is the statute that permits an additional award of PTD or PPD after the first award or arrangement of compensation. The phrase "for worsened conditions resulting from the original injury" refers to the condition resulting from the original injury that gave rise to the initial award or arrangement of compensation. If that condition worsens and the worker's earning capacity further is reduced, ORS 656.216(5), the worker is entitled to additional disability compensation. The phrase does not refer to other conditions such as age, education or health conditions unrelated to the injury-caused health condition.

The approach advanced by the claimant is simple but incorrect. His formula is: (Lost earning capacity at time of second hearing) less (lost earning capacity at time of first hearing) equals worsening. This approach overlooks the requirement of ORS 656.273(1) that the condition itself be worsened and would result in employers and insurers paying for a host of disabilities (such as increasing age and other health conditions) that are unrelated to the earlier injury.

True, to recover additional PPD, the worker is

required to demonstrate a permanently reduced earning capacity. But that alone does not establish a "worsening." The claimant must show that the condition that gave rise to the original award or arrangement has itself permanently worsened. This result is consistent with the PPD and PTD scheme. The threshold requirement to recovery of a PTD or PPD award is a permanent injury. The threshold requirement to recover increased PPD or PTD is a greater permanent injury than formerly existed. Here, such evidence is lacking. Indeed, the Board and Court of Appeals both found that, if anything, the condition that gave rise to the original award had improved.

On a worsening claim for additional PPD or PTD, the referee, Evaluation Division and Board should first compare the claimant's present medical condition with the condition at the time of the earlier award or arrangement of compensation. If that condition is unchanged or improved, no further inquiry is necessary, for there has been no worsening.[1]

We agree with the Court of Appeals that the claimant is, in effect, seeking to reopen the 1979 hearing without proving a permanently worsened condition. That determination is final.

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

[1] A condition can "worsen" in many ways. A PPD award for loss of a leg or arm that, after the award, creates problems to other parts (such as the spine), would support an additional disability award, if earning capacity is adversely affected.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Raymond P. Davidson, Claimant.

DAVIDSON,
Petitioner on Reconsideration,

v.

SAIF CORPORATION et al,
Respondents on Reconsideration.

(WCB 83-10512; CA A34909; SC S33090)

In Banc

On petitioner's petition for reconsideration of the decision of the Supreme Court.*

Argued and submitted April 8, 1987.

Robert L. Wollheim of Welch, Bruun & Green, Portland, argued the cause and filed the petition for petitioner on reconsideration.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents on reconsideration.

PETERSON, C. J.

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

* Judicial review of order of Workers' Compensation Board. 78 Or App 187, 714 P2d 1117, *modified on reconsideration* 79 Or App 448, 719 P2d 75, *remanded* 302 Or 153, 727 P2d 122, *former opinion withdrawn, rev den* 302 Or 462, 730 P2d 35 (1986).

PETERSON, C. J.

Stepp v. SAIF, 304 Or 375, ___ P2d ___ (1987), holds that in order to obtain an increased award of permanent disability on a worsening claim filed pursuant to ORS 656.273(1), a worker must show that the condition resulting from the original injury has permanently worsened since the earlier disability award. The threshold question in this case, as in *Stepp*, is whether the claimant has established a permanently worsened condition.

The Court of Appeals first held that he had, *Davidson v. SAIF*, 78 Or App 187, 714 P2d 1117 (1986), and increased his permanent partial disability award. SAIF petitioned for reconsideration, ORAP 10.10. The Court of Appeals thereafter withdrew its first opinion and awarded no additional compensation, stating:

> "In *Stepp v. SAIF*, [78 Or App 438, 717 P2d 216 (1986)], we held that, even though the claimant had suffered an exacerbation, he was not entitled to have his permanent disability award redetermined, because the worsening was only temporary and the condition had returned to pre-aggravation status. He had not proved any permanent worsening. Similarly, in this case, on reconsideration, we find no evidence of perma-

nent worsening of claimant's condition. His worsened condition before surgery was only temporary and, after surgery, he returned to his pre-aggravation status. Even if the full extent of his condition was unknown at the time of the stipulation, claimant still must prove a permanent worsening of his compensable condition in order to obtain an increased award of permanent disability. He has not done so. He is not entitled to any additional permanent disability. It was error for us to have held otherwise."

Davidson v. SAIF, 79 Or App 448, 450, 719 P2d 75 (1986).

The Court of Appeals' analysis and holding on reconsideration is consistent with our holding in *Stepp v. SAIF*, *supra*. Because the claimant's condition after surgery was no worse than before, no permanent worsening was established.

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

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Alton, Harry K., 86-0329M (10/87)
Amoroso, Thomas, 87-0089M (10/87)
Anderson, David, 86-0470M (2,2,10,11/87)
Anderson, Don L., 86-0330M (5,9/87)
Anderson, Joseph A., 83-0160M (3/87)
Anderson, Susan, 87-0153M (8,12/87)
Andrade, Albert Y., 87-0084M (2/87)
Ansbro, James C., 87-0382M (7/87)
Antonio, Audrey Burton, 87-0279M (6/87)
Armstrong, Donald R., 84-0233M (11/87)
Armstrong, John S., 86-0671M (2/87)
Arnett, Edward R., 86-0376M (7,9/87)
Arnold, Donovan L., 87-0500M (11/87)
Arnold, Marc L., 86-0280M (9/87)
Arrant, Leonard, 87-0233M (4,9/87)
Arroyo, Sam R., 86-0649M (2/87)
Arvidson, George L., 84-0581M (8/87)
Ash, John A., 87-0364M (12/87)
Ash, John A., 87-0364M (6/87)
Ashworth, Flora L., 87-0297M (11/87)
Atkins, Dale E., 87-0238M (4/87)
Atleson, Sherri, 87-0593M (11/87)
Baalman, Nicholas A., 87-0315M (6,9/87)
Bagwell, Susan, 87-0424M (10/87)
Bailey, Claude, 85-0030M (6,9/87)
Bailey, David J., 87-0435M (9/87)
Baker, Anthony, 87-0041M (1,2/87)
Baker, Barbara E., 86-0045M (1/87)
Baker, Charles, 87-0529M (10/87)
Baker, Charles, 87-0529M (12/87)
Baker, Howard A., 87-0293M (5/87)
Baker, Robert L., 87-0611M (10/87)
Baker, Steven, 87-0200M (4/87)
Baldwin, Raymond L., 87-0034M (3,8/87)
Ball, John A., 86-0630M (1/87)
Baller, Debra A., 86-0543M (2/87)
Bangs, Jim, 87-0038M (4/87)
Bangs, Larry G., 87-0314M (7/87)
Banta, Wayne A., 87-0524M (9/87)
Barnes-Lentz, Mildred, 86-0071M (5/87)
Barnett, Tom L., 85-0038M (1,8,12/87)
Barney, Frank H., 86-0192M (7/87)
Barrera, David G., 87-0430M (8/87)
Beavers, Clyde, 87-0012M etc. (1/87)
Beeler, James B., 87-0613M (12/87)
Belle, Anna R., 87-0027M (6/87)
Bello, Paul, 87-0606M (10/87)
Bender, Wilma S., 86-0567M (5/87)
Bennett, Linda L., 86-0243M (6/87)
Bennett, Ronald E., 84-0109M (6/87)
Bensen, Jeanette, 87-0736M (12/87)
Benton, James E., 87-0228M (5/87)
Berger, Carl P., 87-0017M (1,2/87)
Bergmen, Clark A., 87-0532M (9/87)
Best, Curtis, 87-0401M (8,9/87)
Bethel, Brian K., 87-0498M (11/87)
Bias, Richard L., 86-0708M (5/87)
Bigby, George S., 87-0254M (5/87)
Bigelow, Audrey J., 87-0539M (11/87)
Bigelow, Grant W., 87-0327M (6/87)
Bigsby, Barbara, 86-0368M (3/87)
Billings, Gerald L., 87-0325M (6/87)
Billups, Terry, 85-0271M (2,6,9,11,12/87)
Birchmier, Douglas, 87-0026M (1/87)
Bishop, Monica, 87-0168M (3,11/87)
Bittner, Edward A., 86-0668M (2/87)
Blacketer, Kenneth R., 87-0135M (4,7/87)
Blair, Joyce D., 87-0310M (6,9,9/87)
Blake, Myron E., 85-0260M (12/87)
Blakely, Bobbie J., 85-0177M (2,12/87)
Blakely, Randy L., 86-0455M (5/87)
Blank, Michael T., 86-0548M (3,3/87)
Blanton, John, 87-0284M (9/87)
Blauvelt, Merrie Jo, 87-0706M (12/87)
Blaylock, James S., 87-0053M (2/87)
Blevins, Jack, 87-0371M (8/87)
Blondell, Curtis, 87-0215M (9/87)
Bodda, Harvey, 87-0312M (9/87)
Bogue, Dick E., 87-0541M (9/87)
Bolling, Douglas E., 86-0428M (10/87)
Booher, Raymond C., 87-0129M (6/87)
Booth, Larry A., 86-0408M (6,9/87)
Booth, Ronald, 87-0578M (10,11/87)
Booth, Stephen B., 87-0235M (4/87)
Borisoff, Henry T., 87-0404M (9,12/87)
Borkowski, Kenneth R., 86-0583M (4,12/87)
Bostwick, Harry R., 87-0441M (8,11/87)
Bowers, James P., 87-0567M (10/87)
Boyce, Lloyd C., Jr., 84-0242M (3/87)
Boyd, Danny L., 87-0142M (3/87)
Boyles, Gary T., 86-0496M (7/87)

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Bradford, Timothy J., 87-0467M (12/87)
Brakefield, Juanita J., 85-0143M (6/87)
Branca, Richard W., 87-0390M (8/87)
Brant, Hilda, 85-0667M (8,10/87)
Braun, Donald J., 87-0196M (5,7/87)
Breazeale, Jerry W., 86-0452M (3,3,7/87)
Breese, Donald E., 87-0360M (8/87)
Brenner, John R., 85-0090M (7/87)
Bridges, Velton L., 81-0049M (5/87)
Brieger, Donald N., 85-0252M (2/87)
Brockie, Robert W., 87-0292M (8/87)
Brookshire, Joy J., 86-0689M (2/87)
Broughton, Emmett, 87-0167M (5/87)
Brown, Charles E., 86-0637M (2,12/87)
Brown, Dorothy, 87-0224M (4,5/87)
Brown, Gary O., 84-0266M (2/87)
Brown, Robert W., 87-0143M (3/87)
Brown, Roger T., 87-0130M (5/87)
Bryce, Mary, 86-0546M (8/87)
Buchanan, Patrick L.,86-0278M (4,11,12/87)
Buck, Nicholas J., 83-0296M (5,8/87)
Bunch, Shirley A., 86-0140M (1/87)
Burgess, Curtis A., 86-0677M (6/87)
Burgess, Paul H., 87-0351M (9/87)
Burres, Joseph L., 86-0614M (1,7/87)
Burton, Audrey, 87-0279M (6,10/87)
Burton, Jack, 87-0674M (12/87)
Bush, Daniel L., 87-0043M (1/87)
Bush, Ernest M., 87-0333M (6/87)
Butler, June M., 87-0474M (9/87)
Butler-Reeves, Kathleen, 87-0432M (9/87)
Caccamise, Chris, 86-0680M (8/87)
Cady, Clare, 87-0225M (6,10/87)
Cady, Lester F., 87-0123M (4/87)
Calkins, Charles R., 85-0127M (1/87)
Calkins, Kenneth W., 86-0632M (8,11,12/87)
Calvin, Otha L., 87-0709M (12/87)
Cambron, Connell R., 86-0703M (1/87)
Cameron, Scott L., 87-0076M (3/87)
Candelaria, Gayle, 86-0420M (10/87)
Carden, Richard D., 87-0422M (9/87)
Carr, Iola P., 86-0706M (3,5/87)
Carrier, Glen A., 86-0701M (1,5,8/87)
Carrington, Virginia M., 87-0610M (11/87)
Carroll, Eldon L., 86-0078M (2,5/87)
Carter, Donald C., 86-0482M (1,6/87)
Carter, Dorothy R., 87-0060M (3,9/87)
Carter, Ronald R., 87-0294M (8,12/87)
Carter, Terry M., 86-0401M (10/87)
Casey, Georgia, 87-0113M (2/87)
Castle, Melvin O., 84-0267M (3/87)
Catto, Dale E., 87-0182M (3/87)
Caywood, Charles N., 86-0160M (12/31)
Center, Gary D., 87-0536M (9/87)
Cerkoney, Patricia J., 86-0099M (3/87)
Cermak, Gary, 87-0616M (11/87)

Name, WCB Number (Month/Year)

Chambers, Lester R., 86-0667M (2/87)
Chandler-Tawney, Theda M., 87-0031M (1/87
Chaney, Orvel L., 87-0290M (5/87)
Charley, Frank J., 87-0507M (12/87)
Cheatham, Verla L., 87-0534M (9/87)
Chew, Vernon, 83-0376M (8/87)
Childers, Larry L., 86-0611M (6/87)
Choi, Sook Ja, 86-0300M (1/87)
Christensen, Beryl Ann, 87-0597M (12/87)
Christopher, Terry L., 87-0712M (12/87)
Clancy, Patrick, 87-0348M (8/87)
Clark, Bobby R., 87-0057M (1,3,9/87)
Clark, Bryan, 87-0579M (12/87)
Clark, Joseph A., 87-0727M (12/87)
Claussen, Karen, 86-0549M (1,2,3/87)
Clayton, Linda, 87-0608M (10/87)
Clemmer, Charlotte A., 87-0544M (10/87)
Clevenger, Delmer, 87-0510M (9/87)
Clough, Robert L., 85-0329M (9/87)
Clough, Robert, 87-0692M (12/87)
Coats, Thomas R., 87-0242M (4/87)
Cobb, Vernon G., 86-0529M (1/87)
Cochran, Charles K., 87-0559M (11/87)
Coen, Daniel E., 85-0532M (3/87)
Coiteux, Linda M., 87-0170M (8,12/87)
Collins, Donna L., 85-0154M (5,11/87)
Comer, Sandra L., 87-0112M (2/87)
Connary, Harold David, 87-0229M (4/87)
Cooper, Iran P., 87-0423M (9/87)
Cooper, Kathryn, 87-0011M (3/87)
Cooper, Leo, 84-0035M etc. (6,6,7/87)
Copher, Edwin L., 86-0669M (3/87)
Cornelius, Irene L., 86-0369M (12/87)
Cornett, Marvin, 85-0601M (6/87)
Cornwall, Christine B., 87-0719M (12/87)
Corwin, Jack L., 86-0635M (8/87)
Cottam, Linda H., 86-0697M (2/87)
Couch, Billie D., 87-0322M (8/87)
Cox, Georgia, 87-0067M (4/87)
Cox, Joseph L., 86-0141M (3/87)
Cox, Reba Jean, 87-0545M (12/87)
Crawford, Richard, 87-0324M (6/87)
Cress, Stanley, 87-0443M (8/87)
Crickmer, Micheal, Jr., 87-0311M (9/87)
Crocker, Samuel, 87-0588M (12/87)
Cross, Kathie, 87-0581M (10/87)
Crossley, William F., 84-0533M (3/87)
Crouch, Michael, 87-0522M (9/87)
Cummins, Mary Jo, 87-0096M (2/87)
Current, Edward R., 87-0681M (12/87)
Cutler, Gary L., 87-0575M (10/87)
Cutright, Florence Paulsen,87-0264M (8/87
Cutsforth, Barbara J., 87-0052M (1/87)
Dale, William J., 87-0029M (2/87)
Dalton, Robert W., 86-0436M (8/87)
Dalton, Robert W., 87-0501M (10/87)

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Name, WCB Number (Month/Year)

Daniels, Gary, 87-0668M (12/87)
Danielson, James L., 87-0259M (5/87)
Darby, Lena R., 87-0039M (3/87)
Darcy, James G., 86-0600M (12/87)
Daugherty, Charles, 87-0419M (10/87)
Davenport, Jack A., 87-0690M (12/87)
David Hernandez, Isabel, 87-0595M (11/87)
David, Charlie E., 87-0416M (9/87)
Davidson, Robert A., 87-0188M (4/87)
Davis, Craig J., 87-0178M (3/87)
Davis, Frances, 87-0689M (12/87)
Davis, Ivan, 87-0146M (4/87)
Davis, Wallace J., 87-0744M (12/87)
Dawley, Frank, 87-0218M (4/87)
Dearmond, Gayford N., 87-0475M (9/87)
Dees, Glenn R., 86-0410M (3,4/87)
Delay, Donald W., 87-0678M (12/87)
Derting, Luther E., 87-0514M (9/87)
DeTour, Ronald L., 87-0604M (12/87)
Diaz, Barbara A., 87-0154M (3/87)
Dilworth, William C., 85-0050M (3,5/87)
Dobbs, Michael, 87-0329M (9,12/87)
Dobson, Dennis A., 87-0213M (4,9/87)
Dodrill, Donald L., 85-0410M (7/87)
Doggett, Kenneth M., 86-0590M (1/87)
Dorrenbacher, Billy J., 85-0552M (8/87)
Dorsey, Terry E., 84-0372M (3/87)
Douglass, Paul, 87-0285M (6/87)
Dove, Jean L., 87-0082M (3/87)
Dowell, Carol Ann, 85-0258M (5/87)
Dugan, Timothy, 86-0662M (6/87)
Duncan, Earl M., 87-0386M (7,11,12/87)
Duncan, James A., 86-0522M (8/87)
Duncan, Robert L., 87-0670M (12/87)
Durbin, Dave, 87-0316M (8/87)
Duren, Bradley D., 87-0370M (8/87)
Dusenberry, Sam A., 87-0087M (2/87)
Dutton, Douglas L., 87-0267M (8,9/87)
Early, Robert F., 87-0338M (6/87)
Eastburn, Susan E., 87-0497M (9/87)
Edwards, Earlene J., 87-0562 (10,11/87)
Edwards, Jeffery, 87-0672M (12/87)
Ehly, Ronald R., 86-0089M (1/87)
Ehmke, Pamela, 87-0270M (9/87)
Elkins, Garry, 87-0302M (5,8/87)
Elliott, Norma J., 87-0021M (1,2/87)
Ellis, Loretta M., 87-0044M (1/87)
English, Carroll D., 87-0205M (6/87)
English, James C., 87-0160M (3/87)
English, Jesse E., 84-0503M (12/87)
Ensign, Gary, 87-0453M (11/87)
Erdahl, Charles L., 85-0456M (7/87)
Erwen, Ted N., 86-0501M (8,11/87)
Eubanks, Billy J., 87-0445M (12/87)
Evans, Arnold "Gene", 86-0385M (1/87)
Evarts, Ola Mae, 87-0557M (11/87)

Name, WCB Number (Month/Year)

Fake, Theodore M., 85-0495M (1/87)
Farrens, Gerald R., 87-0289M (5/87)
Farson, Patricia A., 87-0452M (9/87)
Faughn, Darrell, 86-0551M (3,4,8/87)
Felton, Roxy Dean, 87-0071M (11/87)
Felton, Roxy Dean, 87-0071M (3/87)
Ferebee, John, 87-0208M (8/87)
Fields, Eddie, 84-0536M (8/87)
Firestone, James M., 86-0403M (1/87)
Fisher, Glenn, 87-0214M (4/87)
Fisher, Richard N., 87-0278M (5/87)
Fitzgerald, Gayle, 87-0471M (8,9/87)
Fitzgerald, Jack, 87-0414M (8/87)
Fix, Paul D., 86-0617M (2,6/87)
Flescher, Benjamin R., 86-0573M (1/87)
Fletcher, O.C., 86-0679M (2/87)
Flory, Hazel P., 87-0230M (4/87)
Foltz, Doyle C., 84-0148M (6/87)
Folwick, Marty R., 87-0173M (5/87)
Force, Juanita, 87-0638M (12/87)
Ford, Donald F., 87-0385M (7/87)
Fortenberry, Phillip G., 86-0541M (4/87)
Foster, Howard S., 87-0525M (9/87)
Fourier, Shirley L., 86-0279M (1/87)
Foxe, Jerry, 87-0600M (12/87)
Frame, Earl F., 86-0650M (1/87)
Frame, Earl F., 87-0181M (8/87)
France, Roger G., 85-0310M (3/87)
Franke, Donald M., 86-0097M (4,12/87)
Frazier, Ather, 87-0291M (5/87)
Frazier, Scott, 87-0551M (9/87)
Frear, James, 85-0675M (7,12/87)
Frederick, Carl J., 86-0684M (4/87)
Freeland, Charlotte, 87-0019M (12/87)
Freimuth, Leslie, 87-0222M (5/87)
Froescher, Harold G., 87-0590M (10/87)
Fruichantie, Jerry, 87-0025M (2/87)
Fuestman, Beatrice, 87-0317M (6/87)
Funk, William, 87-0227M (4,8/87)
Gall, Teresa A., 87-0189M (4/87)
Gallegos, Lynda M., 87-0295M (7/87)
Gardner, Leland R., 86-0249M (4/87)
Garrison, Dale A., 86-0515M (3/87)
Gaspard, Joy J., 87-0056M (1/87)
Gatens, Lester W., 86-0461M (5,5,7,8/87)
Gates, David E., 87-0239M (4/87)
Gates, Robert, 86-0197M (12/87)
Gay, Lloyd, 87-0202M (6/87)
Gay, Walter, 86-0130M (5/87)
Gearin, Fred, Jr., 87-0460M (8/87)
Geenty, Richard T., 83-0313M (4/87)
Geenty, Richard, 83-0313M (12/87)
Gentry, Wayne N., 85-0347M (1/87)
Geving, Snowden A., 87-0090M (4/87)
Gibbs, Daniel, 87-0134M (7/87)
Giesbrecht, Robin, 86-0699M (2/87)

Name, WCB Number (Month/Year)

Gieszler, Kwito, 86-0528M (8/87)
Gifford, Elizabeth, 86-0353M (3/87)
Gigoux, John A., 87-0439M (8/87)
Gilder, Kenneth, 85-0682M (9/87)
Gilkey, Arlene, 87-0255M (5,6/87)
Gill, Charles, 87-0489M (9/87)
Gilman, Charles A., 86-0251M (1,6/87)
Gimlin, Rick L., 87-0138M (3/87)
Gimlin, Rick L., 87-0623M (11/87)
Giorgetti, Rudy L., 87-0207M (4/87)
Gipson, DeWayne P., 85-0537M (5/87)
Glazier, Leonard R., 86-0531M (1/87)
Glover, Berenice C., 87-0119M (3/87)
Goedert, Debbie K., 86-0687M (12,12/87)
Goodall, C. Dean, 87-0743M (12/87)
Gordineer, Harley J., 87-0336M (6/87)
Gower, Earl C., 86-0381M (3/87)
Graham, Johnnie T., 87-0133M (4/87)
Graham, William H., 87-0115M (9/87)
Grant, Maxine, 87-0023M (2/87)
Granville, Alton, 86-0597M (12/87)
Graves, Peggy J., 87-0498M (9/87)
Green, Coral, 87-0342M (8/87)
Gregg (Freeman), Laurie, 87-0180M (3/87)
Gregory, Bob A., 87-0677M (12/87)
Gregory, Daniel G., 85-0407M (5/87)
Gregory, Lewis O., 87-0628M (12/87)
Grendler, Jean M., 86-0303M (1/87)
Greve, Everett W., 86-0404M (12/87)
Griffin, Terrance A., 87-0618M (11/87)
Griswold, Debra, 85-0579M (4/87)
Groat, Jerry D., 87-0512M (9/87)
Grover, Leroy J., 87-0081M (2/87)
Gruber, Larry, 87-0262M (5/87)
Guerci, Elizabeth, 87-0069M (3/87)
Guernsey, Craig H., 86-0672M (1/87)
Guerrette, Patsy J., 85-0658M (3/87)
Gunn, Steven C., 86-0222M (1/87)
Gunter, Dana, 87-0209M (10/87)
Gutierrez, Mario, 87-0245M (8/87)
Gutierrez, Santos, 87-0116M (2,9/87)
Gymkowski, Joseph, Jr., 87-0282M (5,8/87)
Hagedorn, Nana D., 87-0527M (9/87)
Hager, James J., 87-0077M (2/87)
Hagg, Mary J., 87-0607M (12/87)
Hagger, Danny G., 87-0639M (12/87)
Hale, Theresa, 87-0566M (11/87)
Hall, Lynn C., 87-0161M (10/87)
Hall, Marina E., 87-0626M (12/87)
Hall, Rebecca, 87-0437M (11/87)
Halter, Paula J., 87-0094M (12/87)
Halter, Paula, 87-0094M (2/87)
Hamilton, Lloyd L., 84-0582M (12/87)
Hamm, James E., 87-0277M (8,11/87)
Hammer, Jack L., 86-0444M (7,9/87)
Hammond, Robert, 87-0305M (11/87)

Name, WCB Number (Month/Year)

Hancock, Jancy K., 87-0152M (6/87)
Hancock, Lee R., 86-0525M (1/87)
Hanson, Craig R., 86-0535M (1,1/87)
Hanson, David A., 87-0093M (2,4/87)
Hardenbrook, James M., 86-0434M (1/87)
Harlin, Betty, 87-0516M (9/87)
Harris, Jack G., 86-0060M (3/87)
Harris, John, 87-0078M (2/87)
Harris, Paul A., 87-0047M (3/87)
Harris, Rex A., 86-0606M (2/87)
Harris, Robert S., 87-0397M (9/87)
Hart, James, 87-0379M (12/87)
Harvey, Herman, Jr., 87-0521M (9,11/87)
Haskett, Merritt W., 87-0425M (8/87)
Hawkins, John H., 87-0158M (4/87)
Hayes, Larry L., 85-0393M etc. (3,9,12/87)
Hedgpeth, Ruth, 87-0353M (8/87)
Hegele, Charles G., 87-0109M (6/87)
Hegele, Charles, 87-0109M (11/87)
Heggstrom, Charles E., 86-0259M (1/87)
Heilman, Robert L., 87-0194M (4/87)
Heintz, Edward V., 87-0494M (9/87)
Henderson, Nonda, 86-0503M (8/87)
Hendrick, David W., 87-0018M (2/87)
Hendricks, James, 86-0640M (5/87)
Hendrickson, Shirley, 86-0169M (3/87)
Hendrix, Calvin K., 86-0050M (4/87)
Henry, Donald W., Jr., 87-0032M (8/87)
Herbert, Gary P., 87-0591M (11/87)
Herron, James M., 86-0466M (1/87)
Hevelone, Ivan B., 85-0269M (12/87)
Hibbs, Wallace, 87-0220M (5,10/87)
Hickman, Darlene, 87-0622M (12/87)
Hickman, Donald, 87-0147M (4/87)
Hicks, Carl W., 87-0413M (8,11/87)
Hiebert, David, 87-0592M (11/87)
Higa, Harold T., 86-0711M (1/87)
Higgins, Roger L., 87-0346M (9,10/87)
Hilderbrand, James R., 86-0012M (9/87)
Hill, David, 87-0001M (5/87)
Hill, Raymond D., 87-0051M (1,4/87)
Hill, Raymond, 87-0633M (12/87)
Hilton, Alice L., 87-0132M (3,8/87)
Hinton, Larry A., 86-0695M (6/87)
Hinzman, Bernie, 83-0097M (8/87)
Hissner Graham, Shirley,87-0166M (3,10/87)
Hlavka, Joseph, 87-0184M (8/87)
Hodges, Leona Mabel, 87-0206M (8/87)
Hodges, Thomas, 87-0462M (9/87)
Hoff, Harley R., 84-0032M (9/87)
Hoiting, Lawrence H., 85-0594M (2/87)
Hoke, Harold L., 84-0476M (9/87)
Holland, Walter, 86-0354M (4/87)
Holloway, James N., 86-0603M (2/87)
Holman, David R., 86-0437M (6,9,9/87)
Holme, Marie, 86-0131M (2/87)

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Name, WCB Number (Month/Year)

Holmes, Loren D., 87-0176M (5/87)
Holmstrom, Paul, 87-0155M (3/87)
Hoover, Robert I., 87-0644M (11/87)
Howard, Richard H., 81-0252M (5/87)
Howlan, Larry E., 87-0221M (4/87)
Hubbard, Edward, 86-0431M (2,12/87)
Huck, Brett W., 87-0049M (5/87)
Hudspeth, William R., 86-0710M (1/87)
Huffman, Milford W., 84-0461M (3,5/87)
Hughes, Randall, 87-0725M (12/87)
Hunter, David O., 86-0218M (3/87)
Hurley, Garold L., 86-0628M (2,3,12/87)
Hurt, Louise, 87-0085M (3/87)
Hutchins, Merle R., 87-0710M (12/87)
Idlewine, James, 86-0122M (8/87)
Imbler, George L., 85-0486M (7/87)
Irving, Lynn B., 87-0266M (7,7/87)
Jackson, Howard, 87-0656M (12/87)
Jackson, Margarite, 84-0256M (6/87)
Jackson, Robert, 87-0185M (4,8,9,12/87)
Jacobe, Joyce A., 87-0211M (4/87)
Jacobson, Bert N., 85-0648M (1,6/87)
Janzen, Clarence, 87-0649M (11/87)
Jaramillo, Richard J., 87-0261M (6/87)
Jeffers, Donald W., 86-0476M (9,12/87)
Jefferson, Ruth, 87-0615M (11/87)
Jensen, Leonard J., 86-0694M (3,4/87)
Jensen, Rex D., 87-0480M (8/87)
Johnson, Arnold R., 87-0654M (12/87)
Johnson, Charles E., 86-0457M (12/87)
Johnson, Clayton W., 87-0241M (4,5/87)
Johnson, Dennis L., 87-0349M (7/87)
Johnson, Frances L., 87-0046M (1/87)
Johnson, Robert V., 87-0339M (7/87)
Johnson, Roy W., 87-0502M (9/87)
Johnson, Stella, 87-0212M (9/87)
Johnston, Michael T., 87-0576M (10/87)
Johnstone, Michael C., 86-0707M (4,6/87)
Jones, Charles C., 86-0576M (1/87)
Jones, Dennis J., 86-0651M (1/87)
Jones, Dennis J., 86-0651M (10/87)
Jones, Tim L., 87-0431M (8/87)
Jordan, George W., 87-0131M (5/87)
Jorgenson, Patricia A., 87-0320M (8/87)
Joseph, Elaine T., 87-0103M (4/87)
Joseph, Elaine T., 87-0394M (8/87)
Jurgensmeier, Ada, 87-0020M (10/87)
Kaiser, Michael J., 87-0513M (9/87)
Karna, Linda Dyer, 86-0306M (9/87)
Katzberg, Ronald L., 86-0272M (5/87)
Kay, Leonard D., 87-0223M (6/87)
Kearl, Carol, 87-0484M (11/87)
Keller, Edwin Lee, 87-0075M (8/87)
Kelley, James K., 87-0450M (8/87)
Kellogg, Lawrence L., 86-0607M (1/87)
Kelly, Jack L., 87-0114M (5/87)

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Kelly, John R., 87-0679M (12,12/87)
Kelly, Robert W., 86-0561M (1/87)
Kelly, Roy E., 86-0321M (1/87)
Kendrick, John C., 86-0370M (4/87)
Kennedy, Dewey, 85-0476M (8/87)
Kennedy, Richard G., 87-0118M (9/87)
Kennedy, Robert E., 86-0629M (1,9/87)
Kennison, Gerald L., 85-0574M (8/87)
Kessler, Barbara L., 87-0601M (12/87)
Kester, Clifford L., 86-0102M (1/87)
Kinaman, Jerry W., 85-0078M (6/87)
King, Edna L., 86-0574M (1/87)
King, Edna L., 86-0574M (12/87)
King, Walter F., Jr., 86-0425M (2/87)
Kinsey, Jerry, 86-0283M (9/87)
Kissee, Ted R., 87-0519M (9/87)
Klein, Larry, 87-0028M (11/87)
Klein, Larry, 87-0028M (2,2/87)
Klein, Tracy, 87-0704M (12/87)
Knight, Dennis E., 87-0617M (11/87)
Knight, Robert A., 86-0363M (7/87)
Knowlson, James C., 86-0666M (8/87)
Kociemba, Leroy A. (6,6/87)
Koehler, Audrey, 87-0175M (3/87)
Koehn, Fred L., 87-0483M (8/87)
Koenig, Phillip D., 87-0232M (4/87)
Koho, Kay E. (Tucker), 87-0157M (3,4/87)
Kreger, Rosetta M., 86-0219M (10/87)
Kroner, Lloyd A., 87-0449M (8/87)
Kundelius, Anthony, 87-0301M (6/87)
Labahn, Arthur J., 85-0334M (3/87)
Ladd, Clayton D., 86-0510M (11/87)
Landers, Arthur W., 86-0402M (2,6,10/87)
Landis, Allen, 87-0405M (8/87)
Laney, Walter, 84-0185M (6/87)
Lang, Christine A., 87-0347M (7/87)
Lang, Terry L., 84-0434M (4/87)
Langton, Thomas L., 87-0102M (12/87)
Langton, Thomas L., 87-0102M (4/87)
Lannigan, Donnie C., 87-0479M (10/87)
Lanz, Ray J., 86-0506M (12/87)
Lanz, Ray J., 86-0506M (5,11/87)
Larson, Frank E., 86-0686M (1,7/87)
Larson, Leonard, Jr., 86-0398M (1/87)
Laur, Harold W., 87-0708M (12/87)
Lauritsen, Kerry L., 86-0570M (1,6/87)
Lawrence, W.E., 87-0383M (7,12/87)
Laxson, Lindsay B., 87-0177M (3,10/87)
Leach, Jack E., 87-0219M (5/87)
LeClaire, Nelson, 86-0545M (3,6/87)
Lee, Terry G., 87-0453M (9/87)
Leeper, Ralph E., 87-0665M (12/87)
Lefors, Kenneth, 87-0720M (12/87)
Lehn, Randall W., 86-0145M (5/87)
Lehnherr, John, 86-0676M (5,6/87)
Leigh, Kenneth, 86-0233M (4/87)

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Leighton, James W., 86-0340M (1/87)
Lenocker, Paul, 87-0624M (11/87)
Lentz, Gordon L., 85-0637M (8/87)
Leonetti, Gregg J., 87-0198M (4,4/87)
Lesh, Lynn, 86-0624M (1/87)
Leslie, Paul E., 87-0715M (12/87)
Lichau, James W., 86-0538M (2/87)
Lindberg, Darylene M., 86-0366M (1,9/87)
Little, Larry L., 87-0361M (6/87)
Littleton, Richard, 87-0145M (3/87)
Lloyd, John, 87-0446M (8/87)
Lodeski, Charlene J., 87-0684M (12/87)
Lofton, Calvin, 85-0663M (3/87)
Loftus, Diane, 87-0538M (9/87)
Logan, Linda L., 87-0509M (12/87)
Logan, Mitchell J., 87-0072M (8/87)
Lohse, Hertha, 87-0243M (10/87)
Lomas, Michael H., 87-0319M (6,7/87)
Lombardi, Linda L., 87-0389M (8/87)
Longanecker, Orval, 86-0491M (8/87)
Loudon, Joanne L., 86-0642M (1,6/87)
Louvring, Gordon E., 87-0343M (6/87)
Lovan, Herman, 87-0546M (9,10/87)
Lucas, Craig M., 85-0643M (4/87)
Lucky, Gary D., 87-0015M (3,6/87)
Lundy, Clyde D., 87-0156M (3,5/87)
Lutes, Stephen G., 87-0201M (4/87)
Lutz, Brian K., 87-0050M (8/87)
Lyons, Charles G., 86-0133M (2/87)
Madigan, John B., 87-0006M (1/87)
Malar, Shirley E., 87-0070M (10/87)
Malar, Shirley E., 87-0070M (5/87)
Mandzij, Della, 87-0121M (3,8/87)
Manning, Larry D., 87-0448M (8/87)
Marlatt, Lester E., III, 87-0742M (12/87)
Marsh, Bruce A., 86-0356M (2/87)
Marshall, Edward F., 86-0682M (2/87)
Marshall, Harvey, Jr., 87-0640M (11/87)
Martin, Charles E., 87-0561M (12/87)
Martin, Elson, 87-0402M (7,12/87)
Martin, Joan E., 87-0586M (12/87)
Martin, Niel P., 86-0620M (3/87)
Martinez, Armando, 86-0252M (2,7/87)
Mathes, Patsy, 87-0024M (3/87)
Matson, Patricia E., 86-0619M (1/87)
Matthews, Ned, 87-0126M (3/87)
Maul, Christopher, 86-0113M (11/87)
Maupin, Eddy V., 87-0122M (6/87)
May, George R., 87-0136M (6,11/87)
May, James R., 87-0352M (12/87)
McAlister, J.D., 86-0388M (12/87)
McAlister, J.D., 86-0388M (2,6,8/87)
McAllaster, John, 87-0574M (10/87)
McCall, Charles W., 87-0491M (10/87)
McCasland, Margie B., 81-0226M (12/87)
McClaurin, Jenevieve, 86-0395M (3,11/87)
McCormick, Kathy B., 87-0144M (3/87)
McCready, Mary, 87-0344M (6/87)
McCutcheon, Newton E., 87-0666M (12/87)
McDarment, Dorotha L., 87-0741M (12/87)
McDougall, Lesley, 87-0669M (12/87)
McFadden, James H., 87-0359M (6/87)
McGhee, Arthur V., 87-0408M (8,9/87)
McGhee, William W., 87-0079M (3/87)
McGill, Harvey, 87-0263M (5/87)
McGrory, A. Brendan, 85-0551M (1,4/87)
McKay, Candy K., 87-0273M (5/87)
McKenney, Robert G., 87-0097M (3/87)
McMahill, Ronald L., 86-0581M (8/87)
McMullen, Alan H., 87-0005M (1/87)
McNamara, Ronald E., 87-0461M (9/87)
McWilliams, Bertha, 87-0384M (9/87)
Meadors, Shuler M., 87-0151M (5/87)
Mee, Donald E., 87-0687M (12/87)
Meek, Joseph L., 86-0663M (1,9/87)
Meeuwsen, Christiana H., 86-0039M (2/87
Melhorn, Thomas, 87-0662M (12/87)
Mercier, Darrel L., 87-0179M (4,5,11/87
Merrill, Mildred D., 87-0472M (11,12/87
Merrill, Sally, 86-0469M (3/87)
Messer, George R., 86-0692M (2/87)
Meyer, Robert, 86-0305M (3/87)
Michael, Vernon, 81-0201M (6/87)
Mikolajczak, James J., 87-0465M (8/87)
Miley, James D., 87-0369M (7/87)
Miller, Barbara, 87-0619M (12,12/87)
Miller, Beverly L., 87-0236M (5/87)
Miller, David R., 87-0204M (5/87)
Miller, Delbert J., 87-0064M (1/87)
Miller, Donald K., 85-0033M (6/87)
Miller, George Irving, 87-0217M (5/87)
Miller, Harry M., 87-0105M (4,6/87)
Miller, Mildred P., 86-0705M (3,7/87)
Miller, Steven D., 85-0010M (6/87)
Mills, Dennis, 87-0030M (1,6/87)
Mindt, Herbert, 87-0517M (9/87)
Minnick, Gary L., 87-0426M (8,12/87)
Minor, Wynona M., 87-0634M (12/87)
Mitchell, Karl E., 86-0064M (3,6,12/87)
Modaff, George A., 86-0304M (1/87)
Monroe, Jack G., 86-0327M (5/87)
Moon, Carroll C., 85-0316M (7/87)
Moore, Clayton, 85-0549M (5/87)
Moore, Jack D., 86-0609M (1/87)
Morgan, Rilene L., 87-0663M (11/87)
Morley, Ralph W., 86-0638M (2,8/87)
Morris, Christopher M., 87-0392M (8/87)
Morris, Clifton G., 86-0601M (2,5/87)
Morrison, Howard E., 87-0124M (6/87)
Mowry, Robert L., 85-0131M (9/87)
Moyer, Phillip D., Sr., 84-0083M (11/87)
Muir, Michael, 87-0150M (4/87)
Mull, Kenneth, 87-0330M (10/87)
Mullen, Gary L., 87-0481M (9/87)

Name, WCB Number (Month/Year)

Mullen, Lois, 87-0299M (6/87)
Murphey, Charles E., 85-0217M (6/87)
Murphy, Darreld R., 87-0148M (4,7/87)
Mustoe, Erwin R., 83-0388M (3/87)
Nairin, Grant W., 87-0635M (11/87)
Neal, James W., 86-0462M (1/87)
Neal, James W., 86-0462M (10/87)
Neault, Marji M., 87-0190M (5/87)
Nelson, Mary E., 86-0652M (2/87)
Nelson, Michael, 87-0676M (12/87)
Neuman, Sarah L., 87-0584M (10/87)
Newingham, Donald F., 87-0091M (4/87)
Newkirk, Ellena D., 87-0098M (3/87)
Newson, Robert L., 85-0585M (7/87)
Nichols, Joe, 87-0503M (9/87)
Nipper, H. Elvis, 87-0482M (9/87)
Noggle, Richard, 87-0073M (6,12/87)
Nordstrom, William D., ?-0707M (12/87)
Norrander, Ralph H., 87-0007M (1/87)
Nugent, Carole P., 87-0504M (12/87)
Nunez, Gary G., 86-0685M (1/86)
O'Connor, Bernard M., 87-0478M (8/87)
O'Keefe, Daniel, 86-0474M (2/87)
Ochampaugh, William,87-0199M etc.(8,12/87)
Oiler, Jimmie D., Jr., 86-0505M (3/87)
Oland, Delmar, 87-0037M (1/87)
Oliver, J.C., 87-0055M (1,5/87)
Olsen, Mary M., 85-0309M (8/87)
Olson, Allan D., 84-0161M (5/87)
Olson, Robert O., 85-0297M (5/87)
Ontiveros, Timoteo, 87-0556M (12/87)
Osborn, Rachel B., 85-0465M (10/87)
Osborn, Rachel B., 85-0465M (6,8/87)
Osorio, Martha O., 87-0724M (12/87)
Ownby, Laurena, 84-0324M (6/87)
Ozment, Bonnie L., 87-0713M (12/87)
Pace, Lynda R., 87-0323M (6/87)
Palmer, James F., 87-0286M (12/87)
Palmer, James F., 87-0286M (7/87)
Palomo, Victor, 86-0621M (2/87)
Papaioannou, Theodoros, 87-0381M (7/87)
Parker, Lee Roy, 87-0065M (3/87)
Parks, Delbert W., 87-0313M (5/87)
Parr, Robert A., 87-0165M (4/87)
Parrett, Robert, 87-0451M (8/87)
Parrish, Delano C., 87-0159M (3/87)
Partible, John, 87-0647M (11/87)
Partida, Frank, 86-0623M (5/87)
Passmore, George G., 87-0345M (6/87)
Patterson, Archie B., 84-0285M (5/87)
Peabody, Eileen M., 87-0732M (12/87)
Peabody, Horace, 87-0493M (11/87)
Peabody, Rick B., 86-0704M (1/87)
Peacock, James, 87-0062M (2,3,4/87)
Peacock, Stephen J., 87-0362M (7/87)
Pedersen, Robert D., 87-0193M (5/87)
Pederson, John L., 87-0376M (8/87)
Pell, Richard, 85-0479M (12/87)
Pentkowski, Edward J., 85-0111M (12/87)
Perisho, Zenas A., 87-0409M (8,12/87)
Perkins, Bradley H., 85-0694M (9/87)
Perry, Robert, 87-0506M (9/87)
Peters, Fred, 87-0444M (9/87)
Peterson, Leonard, 87-0066M (3/87)
Peterson, Marlene E., 86-0024M (7,10/87)
Pfau, Peter A., 86-0594M (3/87)
Pfleuger, Becky, 86-0593M (4,7/87)
Philippi, Wesley I., 87-0410M (11/87)
Phillips, Donald, 87-0380M (7,9,12/87)
Phillips, Richard C., 87-0463M (8/87)
Phillips, Robert G., 87-0251M (8/87)
Pickering, D. Stephen, 86-0688M (9/87)
Pierson, Georgia L., 87-0377M (7/87)
Pinkham, Berkley Joe, 86-0625M (3/87)
Pishion, Herbert O., 87-0231M (8/87)
Pittman, Beulah, 87-0505M (9/87)
Pitts, Carl D., 86-0508M (2,4/87)
Plum, Edgar E., 87-0614M (11,12/87)
Poelwijk, James, 86-0627M (5,5/87)
Pollock, Joseph, 87-0526M (9,10/87)
Pool, Naomi, 87-0645M (11/87)
Porter, Darrell, 86-0661M (6/87)
Porter, Harris H., 87-0244M (5/87)
Potts, Clarence, 87-0469M (8/87)
Potts, Robert D., 85-0491M (8/87)
Powell, Edgar, 85-0656M etc. (12/87)
Powell, James H., 87-0045M (1,9/87)
Powell, James H., 87-0045M (12/87)
Pratt, Kevan, 86-0125M (12/87)
Prettyman, Earl J., 87-0495M (9/87)
Prian, Joseph D., 86-0372M (1,3,7/87)
Priddy, Vernon D., 87-0137M (3/87)
Prince, Larry E., 87-0468M (8/87)
Pritchard, Debra K., 86-0240M (8/87)
Prock, Peggy, 87-0303M (7/87)
Promitas, James N., 87-0661M (12/87)
Puckett, Elfreta R., 87-0367M (9/87)
Puckett, Robert V., 87-0400M (8/87)
Queener, Gary L., 86-0646M (12/87)
Queener, Gary, 86-0646M (1,3/87)
Quimby, David, 85-0565M (2/87)
Quinlan, Karen M., 87-0492M (11/87)
Rackley, Gene, 86-0690M (3/87)
Ragland, Johnny, 86-0277M (3/87)
Ramsay, Joseph W., Jr., 85-0246M (10/87)
Randahl, Keith D., 86-0236M (1/87)
Randall, Grace M., 87-0016M (6/87)
Randall, Lindi G., 87-0268M (5/87)
Rauschert, John L., 87-0357M (12/87)
Rautenberg, Larry L., 85-0205M (1/87)
Ray, Esther B., 86-0287M (3/87)

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Name, WCB Number (Month/Year)

Ray, James R., 85-0057M (5/87)
Reed, Michael C., 84-0513M (11/87)
Reed, Robert R., 87-0457M (9/87)
Reese, Georgia L., 87-0646M (12/87)
Reeves, Marsdell, 86-0309M (6,12/87)
Reid, Albert W., 87-0059M (3/87)
Rekow, Michael R., 87-0186M (4/87)
Remund, Sharon M., 87-0256M (5/87)
Reynolds, Becky J., 87-0427M (9/87)
Rhodes, Hoover, 87-0110M (3,10/87)
Rice, William L., 87-0099M (2/87)
Richards, Stanley L., 87-0210M (4/87)
Rimer, Robert, 87-0485M (9/87)
Robbins, Janette M., 86-0647M (12/87)
Roberts, Starlee E., 86-0391M (2/87)
Rogers, Brian M., 87-0010M (1,5,10/87)
Rogers, Gayle Keith, 85-0654M (5/87)
Rogers, Richard, 85-0600M (2/87)
Roller, Charles W., 87-0337M (6/87)
Rondeau, Tom, 87-0691M (12/87)
Ropp, Ronald L., 87-0565M (11/87)
Roppe, Arthur D., 85-0106M (8/87)
Ross, Wiley G., 85-0454M (1/87)
Rost, Lou A., 86-0494M (1/87)
Rottacker, Natalie, 86-0223M (5,6/87)
Roundy, Lee M., 87-0388M (7/87)
Roush, Richard L., 84-0018M (6,8/87)
Rowan, John T., 86-0413M (1,3,12/87)
Royer, Peggy A., 86-0399M (2/87)
Roylance, Jerry R., 87-0048M (2/87)
Ruff, Jerry, 86-0460M (8/87)
Rutledge, Darrel A., 87-0265M (11/87)
Sadler, Richard R., 87-0587M (10/87)
Salchenberg, Michael D., 87-0667M (12/87)
Salinas, John E., 86-0485M (12/87)
Salinas, John E., 86-0485M (2/87)
Salinas, Rosalio L., 87-0466M (8/87)
Salsgiver, Joseph C., 86-0660M (8/87)
Salzer, Sharon K., 87-0438M (10/87)
Salzer, Sharon, 86-0070M (3,4,5,6/87)
Sampson, Fred T., 87-0528M (9/87)
Samudio, Rudolph, 87-0326M (6,12/87)
Sanborn, Rodney L., 86-0589M (1/87)
Sanders, Leonard, 87-0363M (12/87)
Sandstrum, Jack, 87-0722M (12/87)
Sandusky, Richard F., Jr., 87-0009M (1/87)
Sarduy, Jorge L., 87-0111M (2/87)
Sayre, Eugene, 86-0190M (3/87)
Schaffer, Lucine T., 87-0234M (5/87)
Schmid, Kenneth G., 86-0618M (1,10/87)
Schram, Debra L., 86-0069M (3,4/87)
Schultz, Clayton R., 87-0246M (4/87)
Schulze, Ruby, 87-0406M (9/87)
Scott, Elva L., 87-0391M (9/87)
Scott, Jeffrey J., 87-0249M (5,11/87)
Scroggins, Ronald, 87-0004M (1,4,9,12/87)
Seaberry, Henry, 87-0395M (8/87)
Sears, Ardith DeJong, 87-0101M (8/87)
Sease, David A., 86-0498M (1/87)
Seaton, Robert M., 87-0496M (11/87)
Sebastian, Delores Jean, 87-0107M (3,6/87)
Seehafer, Douglas, 85-0504M (5/87)
Self, Ira D., 86-0242M (5,12/87)
Serna, Guadalupe, 87-0058M (6/87)
Sevey, Julius B., 86-0569M (1/87)
Sexton, Joseph, 87-0560M (12/87)
Shanklin, Raymond K., 87-0547M (12/87)
Shaw, Catherine R., 87-0318M (6/87)
Shaw, Terri Zemp, 87-0195M (4,6,8/87)
Shelden, Vernon, 86-0495M (5/87)
Shepherd, Donna, 87-0518M (10/87)
Shepherd, Donna, 87-0518M (9/87)
Sheridan, Charlotte M., 87-0642M (12/87)
Sheythe, Keith E., 87-0374M (7,8,12/87)
Shilling, Donna J., 86-0302M (3/87)
Shipman, Orville D., 86-0653M (1/87)
Shipman, Orville D., 87-0680M (12/87)
Shipman, William L., 87-0074M (2,3/87)
Shoemaker, Sammy J., 85-0641M (12/87)
Short, Kenneth, 86-0387M (6,12/87)
Short, Lloyd, 87-0274M (7/87)
Shreeve, George, Jr., 86-0678M (2,9/87)
Shrum, Jean A., 86-0550M (1/87)
Sidener, Thomas F., 87-0240M (4/87)
Sifuentez, Jose A., 87-0643M (12/87)
Silvers, Orlan, 86-0608M (11/87)
Simer, Frederick T., 85-0440M (8/87)
Simmons, Roy D., 86-0604M (7/87)
Simmons, Roy D., 87-0696M (12/87)
Simpson, John D., 86-0345M (3,3,4/87)
Sims, Marvin L., 84-0322M (5,10,11/87)
Sinnott, Harold, 87-0486M (8/87)
Skipper, Mary L., 87-0429M (8/87)
Sletager, Clarence H., 86-0418M (3/87)
Smail, Jeffery, 87-0300M (9/87)
Small, Judith L., 87-0694M (12,12/87)
Smith, Betty J., 86-0212M (3/87)
Smith, Edward D., 87-0637M (12/87)
Smith, Edward G., 85-0352M (5/87)
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